VOICE OF THE DIABETIC

A SUPPORT AND INFORMATION NETWORK

The Diabetics Division of The National Federation of the Blind

Volume 7, No. 2 **Spring Edition** **Page 1**

No longer diabetic? Reflections on kidney and pancreas transplantation

by Donovan Cooper

Donovan Cooper, a leader in the National Federation of the Blind, describes his experiences with kidney and pancreas transplantation.

From the Editor: Donovan Cooper has been an active member of the National Federation of the Blind (NFB) for about twenty years. He is president of the San Fernando Valley Chapter and the Diabetics Chapter of the NFB of California. He is also involved in numerous other Federation activities.

In his article, Donovan reports on his experiences with kidney and pancreas transplantation, which are enlightening. In the next edition of the ***Voice****, there will be a story by Donovan in which he explains methods of paying for kidney/pancreas transplantation.*

On June 24, 1991, I received a telephone call at 5:00 a.m. from the University of Minnesota Transplant Center. I was told that they had a tissue match and that, if I wanted to take advantage of this opportunity, I should catch the next flight to Minneapolis for a combination kidney/pancreas transplant. Because personnel at the Transplant Center knew that I lived in southern California, I was informed that the next direct flight from Los Angeles International Airport (LAX) to Minneapolis/Saint Paul would be at 7:00 a.m. California time. I was asked if I would be able to make that flight and I said that I thought I could. I hung up the phone and immediately went into action.

I called Northwestern Airlines, the carrier to which I had been referred, to confirm the seven o'clock flight time. I then called my boss's Voice Mail to tell him the news and that, of course, I wouldn't be at work that day. I then called my sister who lives in a Minneapolis suburb to ask her if she could pick me up at the airport and take me to the hospital for my surgery. She was quite excited and responded enthusiastically to my request. I also called a few friends — "Nancy, I'm sorry, but I won't be in town to run the next chapter meeting ..." "Claudia, guess what! I'm going to be in Minnesota for awhile, so can you pick up my mail from Julius, sort through it, and send the important stuff to my sister's house? Oh, pick up my cleaning too, will you? ..." "Julius, I'm going to Minnesota for my transplant. Will you pick up my mail and hold it for Claudia until I return?"

I was both nervous and excited at the prospect of getting my transplant. I had been suffering from diabetic kidney disease for more than six years and, although it had progressed slowly, it had become increasingly troublesome. I had received my first hemodialysis treatment only the Friday before, and on this Monday morning I knew that there would be no more. I had been an insulin-dependent diabetic for forty years with all of the related responsibilities and several of the complications. Here was the opportunity for which I had planned and waited.

During the previous year I had investigated transplant options; I had investigated insurance coverage provisions associated with my employer's health insurance options; I had been to the University of Minnesota for a week-long pretransplant workup and I had investigated whether a living-related or cadaver donor would be preferable or even possible. I began a program of pretransplant con-

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Voice of the Diabetic is a national publication of the Diabetics Division of the National Federation of the Blind. It is read by those interested in all aspects of blindness and diabetes. We show diabetics that they have options regardless of the ramifications they may have had. We have a positive philosophy and know that positive attitudes are contagious!

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The National Federation of the Blind

The National Federation of the Blind is the largest organization of the blind in the United States. Interested sighted persons also join. Founded in 1940, the Federation has grown to include more than ten percent of the nation's blind (over 50,000 members).

The Federation is organized in every state and has local chapters in almost every community of any size in the nation. Where there is no local chapter, there are members at large. Each year the National Convention of the Federation is attended by approximately 2,500 blind persons, which makes it the largest gathering of blind people in the history of the world and one which is growing each year.

The ultimate purpose of the National Federation of the Blind is the complete integration of the blind into society on a basis of equality. This objective involves the removal of legal, economic, and social discriminations; the education of the public to new concepts concerning blindness; and the achievement by all blind people of the right to exercise to the fullest their individual talents and capacities. It means the right of the blind to work along with their sighted neighbors in the professions, common callings, skilled trades, and regular occupations.

There are numerous governmental agencies and private charitable organizations and foundations providing services for blind people, but only the blind themselves (acting through their own organization) are able to speak for the blind. This is a basic concept of democracy.

The Newly Blind

Blindness knows no discrimination. Any child can be born blind. Any individual can become blind in childhood or later life. It is in the best interest of every individual to understand blindness and how to cope with its problems.

The newly blinded person faces a difficult adjustment. Studies have shown that only cancer is feared more than blindness. However, blindness does not need to be the tragedy which it is generally thought to be. One of the best medicines is to meet other blind people and learn of their jobs and the techniques they use in doing things without sight. Membership in the NFB provides this common meeting ground and, even more important, a sense of participation and restoration of confidence. Members in the NFB contact newly blinded persons to help them with problems of adjustment and orientation. Local chapters ordinarily hold monthly meetings, and state organizations usually meet annually. The National Convention is held each summer in a major American city and is the ultimate authority of the Federation, which establishes all policy.

The newly blinded person must also know where and how to get the training and services he or she needs. The National Federation of the Blind can work with the person to find and provide information on available services from governmental and private agencies, as well as facts about laws and regulations concerning the blind. More and more governmental agencies and private foundations are becoming responsive to the views and needs of the blind and are learning new concepts and attitudes about blindness. The future looks bright. There is an overwhelming feeling of goodwill and a wish to help on the part of the general public. Most important of all, the blind are moving forward to speak for themselves and take a hand in the management of their own affairs through their organization, the National Federation of the Blind.

Programs and Services

Public Education — By means of speeches, pamphlets, and radio and TV appearances, members of the NFB strive to educate the general public to the fact that the blind are normal individuals who can compete on the basis of equality with their sighted peers.

The *Braille Monitor* is a monthly publication of the NFB devoted to issues, news, and events which have special significance to the blind. It is published in Braille, in print, on record, and on cassette and is available without cost to the blind and sighted alike upon request to the National Office of the NFB.

Job Opportunities for the Blind — Blind persons seeking employment may use regular public and private employment agencies. However, because of widespread misconceptions about the abilities of the blind, special employment services may be more helpful. Blind people today work as lawyers, psychologists, machinists, farmers, and hairdressers; but the best estimates indicate that 70 percent of those who are able to work still do not have jobs or work only a few days a month in sheltered workshops. Many thoroughly capable blind persons have never had a job.

To respond to this critically high unemployment rate, the National Federation of the Blind, in cooperation with the United States Department of Labor, developed a program called *Job Opportunities for the Blind*. JOB helps qualified blind people who are looking for work find employers with job openings. JOB also helps employers, seeking competent workers and compliance with affirmative action requirements for hiring the handicapped, find truly qualified employees. JOB conducts educational seminars about blindness for employers and career-planning seminars for unemployed blind people.

Protection of Rights — There are barriers to full participation in society by the blind. The National Federation of the Blind stands ready to help blind people overcome these barriers when collective action is necessary to invoke protection of applicable state and federal laws in such areas as employment, education, housing, insurance, public transportation, and public facilities.

Social Security Benefits — Legally blind persons who have paid into the Social Security system may be eligible for Social Security Disability Insurance (SSDI) under the special rules which apply to the blind. Legally blind senior citizens considering early retirement should first learn if they might qualify for more benefits under SSDI. Blind persons who have little or no regular income or savings may qualify for monthly payments under the Supplemental Security Income (SSI) program. Again, there are special rules which apply only to the blind. Local Social Security offices have information and applications. The National Federation of the Blind can help with problems in understanding the regulations, incorrect denial of benefits, or related problems.

Rehabilitation — Every state has a public rehabilitation or vocational rehabilitation agency which provides training, counseling, and employment placement services to the blind. Sometimes the service is provided directly, and sometimes it is contracted out to private rehabilitation facilities. Some funds through the rehabilitation agency are usually available to students for college education or other post-secondary training. The NFB's National Office can provide information about where to apply for services in your area.

Library Services — Every state has free library services for those who, because of a physical or visual defect, cannot read ordinary print books. Books and magazines are available (on loan or free of charge) in Braille, in large print, and on cassette and record. Special cassette machines and record players to use in listening to the taped or recorded reading matter are also loaned without cost to blind library users. For details about where and how to apply for services in your area, you may contact the NFB or your local library.

Free Reading Matter Mail Privilege — Recorded, Braille, and large print reading matter (including library books and magazines) may be mailed to and from blind persons free of charge if "Free Matter for the Blind" is written or stamped on the envelope or package. Braille watches, white canes, or other special appliances for the blind are included in this privilege. The NFB will be happy to answer questions about the Free Reading Matter mail privilege.

Education of Blind Children — The passage of Public Law 94-142, the Education of All Handicapped Children Act, established certain rights and protections for blind children and their parents. Blind children are now entitled to a free public education in the "least restrictive environment," and parents have the right to help plan their child's educational program. Contact the NFB for more information about the education of blind children, parent organizations, newsletters, etc. Also, the National Federation of the Blind publishes a magazine for parents of blind children. This publication provides information and insights into all aspects of raising blind children from infancy to adulthood. A free subscription is available to parents and other interested persons by writing to *Future Reflections* at the NFB National Office.

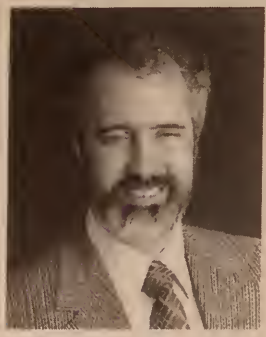
Scholarships — Blind students can take advantage of the same scholarship programs that are available to sighted students and should be encouraged to do so. However, there are also scholarships which are only available to blind students. The National Federation of the Blind, for example, awards over $70,000 a year in scholarships to worthy blind students. Contact the NFB for further details about these and other special scholarships for the blind.

Products and Aids — Technology has made many useful products available to the blind. Some aids make daily life easier (for example, the Braille watch), while others have opened up more employment opportunities for the blind (for example, talking computers). The NFB can supply information about local and national resources regarding products and technology for the blind.

For more information about any of the above programs and services, contact us at: National Federation of the Blind, 1800 Johnson St., Baltimore, MD 21230; telephone: (410) 659-9314.

Diabetic men, impotence, and how to prevail

by Ed Bryant



Ed Bryant, Editor, *Voice of the Diabetic* reports that Impotent men have options.

By providing accurate, up-to-date information through its support and information network, the Diabetics Division of the National Federation of the Blind continues to reach out to those interested in diabetes and its ramifications. One such ramification is erectile dysfunction, commonly known as impotence. In this article, I will discuss this sensitive complication of diabetes. It can be devastating for both the diabetic man and his partner. Sexual intercourse is a natural function, and when the male is unable to perform, the result can be shattering. Erectile dysfunction has long been recognized as a negative element in human relationships. In reviewing various articles on impotence, I noticed that a quotation of the Russian writer Leo Tolstoy was repeatedly used. It is quite appropriate for this discussion. Tolstoy wrote, "Man survives earthquakes, experiences the horrors of illness and the tortures of the soul, but the most tormenting tragedy of all times is and will be the tragedy of the bedroom." What happens — or does not happen — in the bedroom can and does break up relationships.

IMPOTENCE IS COMMON AND CAN BE SUCCESSFULLY TREATED

Erectile dysfunction is the inability to achieve and maintain an erection adequate for sexual intercourse that is satisfying to both partners. In the nation's population, an estimated 15 million men are afflicted with erectile dysfunction, which means that about one out of every eight men suffers from the condition. Even though it is common, erectile dysfunction is so devastating that most men won't talk about it, and many men never seek help. Informational sources report that more than 50 percent of diabetic men will experience this complication during their lives. Fortunately, as reported in numerous professional publications, MOST CASES OF IMPOTENCE CAN BE SUCCESSFULLY TREATED. Bruce MacKenzie, co-founder of the Impotence Institute of America, states, "It is estimated that better than ninety percent of impotent men are successfully treated. Both the man and his partner expressed satisfaction." With treatment available for this common problem, a diabetic experiencing difficulty does have options. It isn't something he — or any other man — should have to live with.

PHYSIOLOGY OF ERECTION

Before discussing erectile dysfunction, I'll briefly review how an erection occurs. The penis is the mechanism that allows the male to perform, and like all other organs, it receives signals from the brain. The sex drive, or libido, is instinctive. To satisfy sexual desire the brain responds to physical or emotional stimuli by signaling the parasympathetic nervous system, which releases a substance that causes dilation of the small arteries in the penis. The increased flow of blood fills the sinusoids, networks of spongy tissue inside each of the two erectile chambers. Also known as the corpora cavernosa, the erectile chambers are located on each side of the penis. The expanded, blood-engorged network of sinusoids presses against the veins that normally transport the blood out of the penis, trapping the supply of blood; the expanded erectile chambers cause the penis to enlarge and stiffen.

After ejaculation, or when sexual stimulation diminishes, the arteries constrict, and the veins expand, allowing the blood to flow out; the penis becomes flaccid (soft). Erection is a function of the parasympathetic nervous system. However, because orgasm and ejaculation are controlled by another set of nerves — the sympathetic system — both orgasm and ejaculation can occur without an erection.

Achieving and sustaining an erection requires interaction between the neurological, arterial, hormonal, and psychological functions of the body. In other words, proper hormonal balance, normal sex drive and emotional make-up, functioning nerves and blood vessels, and healthy penile tissue are all required for an erection.

Although sexual functioning declines with age, a man who is healthy physically and emotionally is able to produce erections and enjoy sexual relations regardless of his age. University studies indicate that 75 percent of healthy men over the age of 70 engage in sexual Intercourse at least once a month, and 25 percent of those over age 78 still have sex regularly. Impotence is not considered part of the aging process.

On occasion a healthy man will be unable to have an erection. Such transient episodes are common and may be attributed to illness, fatigue, or stress, etc. Rest, relaxation and a return to health usually restore normal erectile function. The occasional inability to have and sustain an erection is normal.

PSYCHOLOGICAL CAUSES OF DYSFUNCTION

Repeated inability to have and sustain an adequate erection is considered to be erectile dysfunction. It can be caused by anything that affects a man psychologically and/or physically. Psychological bases include anxiety, depression, tension, guilt, stress, fear, marital problems, etc. Psychological impotence, also called psychogenic impotence, can be associated with major life changes, such as divorce or loss of job. Some of the psychological origins of erectile dysfunction are reflected in descriptive names. For example, "widower's syndrome" is a condition in a man undergoing the bereavement process after the death of his wife. When men who become erect with one of their partners are unable to achieve erection with others, they are experiencing one example of "situational impotence". "Performance anxiety" is experienced by men who become anxious about their ability to have sexual intercourse. Perceived inadequacy may cause them to avoid sex. "Intermittent impotence" describes alternating dysfunction and function. This may be psychological and/or physical in origin. Another cause of dysfunction, of special interest to diabetic men, is the fear of becoming impotent. Knowing they are at risk of developing the dysfunction, they actually become impotent. When the diabetic discovers that the source is not physical — that it is due to fear — sexual function is usually restored. Impotence in a diabetic usually has physical causes; however, not all diabetic men experience this complication.

Determining the cause of erectile dysfunction requires examination by a doctor skilled in diagnosing impotence. Based on findings during the physical examination and interview, the physician can quickly determine if the origin is psychological, physical, or a combination of both. Sudden-occurring cases can usually be attributed to psychological causes.

Impotence itself can contribute to psychological problems such as feelings of inadequacy, frustration, loss of self-esteem, and despair. Strained relationships with partners may result. It is important for men to discuss the problem with their partners and to seek medical attention. Many men experiencing erectile dysfunction find counseling helpful in managing the related stress and other psychological problems.

PHYSICAL CAUSES OF DYSFUNCTION

Physical sources may be disease such as diabetes, vascular diseases, surgery or radiation treatment in the area of the groin, or it may be injury — especially spinal cord injury, or endocrine problems such as hormonal abnormalities, multiple sclerosis, and prostate infections. Alcohol abuse, side effects of prescribed or illegal drugs, and smoking are also factors. It is reported that 70 percent of the cases in the U.S. are attributable to diabetes and vascular disease. Of that 70 percent, 40 percent are caused by diabetes alone. Diabetic impotence is generally a result of the blockage of blood vessels responsible for erection, defects in the nerves that dilate those blood vessels, or a mixture of the two.

In the past, it was believed that psychological factors contributed to most cases of impotence. Today, however, research reveals that 90 percent are caused by physical (organic) factors.

PREVENTION OF ERECTILE DYSFUNCTION

Before discussing specific treatment options for erectile dysfunction, a word or two about prevention is needed. A diabetic man can decrease his risk of becoming impotent by carefully controlling his diabetes. In many cases poorly controlled blood glucose decreases libido or sex drive. In addition to keeping his blood glucose under control, he should also keep cholesterol at a normal level. As mentioned above, one of the leading causes of erectile dysfunction is vascular disease. As the diabetic male ages, poorly controlled diabetes and high cholesterol increase the chances that he will develop vascular problems, especially vessel blockage, which may result in other serious cardiovascular problems as well as in erectile dysfunction. The diabetic should avoid using nicotine and alcohol, not only for the sake of maintaining the vascular system but also for the sake of being able to function sexually. Smoking causes constriction of the blood vessels and contributes to arterial blockage. The connection between alcohol and impotence has been apparent for centuries. William Shakespeare said, "It provokes the desire but it takes away the performance." Exercise on a regular basis is recommended. Generally speaking, good health practices contribute to prevention of impotence in all men.

IMPOTENCE IS A WARNING!

Remember that impotence is the chronic, physical inability to have and sustain an erection adequate for sexual intercourse. Although this article deals with specifics of erectile dysfunction, you should be aware that many believe that impotence is a symptom of a more serious disorder. Seeking early medical help for dysfunction can lead to early diagnosis of other serious disorders before symptoms particular to those disorders appear. Discovery of the source

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Are we still living in the dark ages?

by Eileen V. MacKenzie

Why is the public still in the dark about impotence — why are so many medical professionals still telling patients "Nothing can be done" — why do those professionals who diagnose and treat impotence refuse to use certain treatments?

Remember the old saying "What is one man's meat is another man's poison." Why refuse injection therapy — it has been the "meat" for thousands. Why refuse external management — it has been the "meat" for thousands. Why knock implants — the saving grace of many couples. Each treatment has served the purpose for which it was designed, not just in the USA but throughout the world.

I have spent ten years learning about the causes and treatments of impotence — from books, from doctors, and from patients. Sometimes I am ready to throw in the towel — I am tired of patients who refuse to come out of the closet, even anonymously; tired of professionals who do not read up on new technology and learn that "something can be done"; and tired of those "qualified" (!) physicians who do not discuss all treatment options, or refuse to offer a specific treatment for no other reason than their personal preference.

No one individual is all wise on Earth — neither the patient nor the healing physician. Let's get out of the dark ages.

(*Note:* This article appeared in the Spring 1991 issue of *Impotence Worldwide,* published by Impotence Institute of America. Reprinted with permission.)

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My struggle with impotence

by Ed Eames

Ed Eames, pictured with his wife, Toni, their guide dogs, and cats, explains how he overcame impotence.

It is always difficult sharing a personal part of one's life with strangers. However, sharing one's most intimate problems can make friends of strangers. I hope after reading what I write you will feel you have a friend to turn to. I had no such friend when I went through my ordeal of impotence.

Before meeting my wife, Toni, I was in a stagnant marriage that had become nonsexual. After meeting Toni and reviving my sexual interests, I realized I had serious problems, which I attributed to guilt and the impending divorce. When I got an erection, which was rare, I lost it within seconds.

In an attempt to deal with my problem, I went into psychotherapy, which lasted for more than a year. My therapist recommended sex therapy, and Toni and I went to see a well-known sex therapist for several months. Throughout this long-lasting, therapeutic program, I gained a great deal of insight into my problems and behavior, but found very little to help me in the sexual area. My sex therapist strongly recommended I have a blood test to see if there was any physiological basis for the sexual dysfunction. The test results showed I was low in testosterone, and I went on a medication regimen. At this point, my hopes were raised that my problems would be solved. However, after several months of treatment it was apparent the medication was having no marked impact.

My relationship with Toni was outstanding and based on deep friendship and many common interests. However, my sexual performance anxiety led to my avoiding any sexual contact and was eroding the relationship. In desperation, I turned to a urologist specializing in sexual dysfunctions. After a perfunctory examination, he suggested a penile im-

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My struggle with impotence

(Continued from page 5)

plant. He made no attempt to convince me of the physiological-based need for this radical solution, which would mean invasive surgery.

After our marriage in 1987, Toni and I moved from New York City to Fresno, California. We continued to be plagued by sexual problems. I saw urologists in Fresno who, once again, felt psychotherapy was needed. If that failed, a penile implant might be the solution. However, they did not suggest any diagnostic procedures that would have established the need for such surgery. They mentioned I was getting older (I was 58 at the time) and still recovering from a divorce which had a profound impact on my life. Following their suggestion, Toni and I turned to therapy once again. The therapy helped us with some of the raw edges of our relationship, but did not touch what was clearly becoming obvious — I was impotent.

My urologist sent me to a men's clinic to be fitted with an external device called the Response. This device consists of a vacuum tube and a cock ring. Using a pumping mechanism, a vacuum is created and blood is forced into the penis, giving a satisfactory erection. However, in my case, within seconds the erection diminished to the point that intercourse was not possible. Once again, our high hopes were dashed and no answers to the failure were provided by physicians.

As I began to admit and recognize my impotence, Toni and I read everything available on the subject. When, in the summer of 1990, we read *It's Not All in Your Head: A Couple's Guide to Overcoming Impotence* by Bruce and Eileen MacKenzie (available from the National Library Service: RC 29603), we realized we were not alone. Eileen and Bruce had traveled the same path. They had been sent for years of therapy and sex counseling without receiving advice that Bruce's impotence could be caused by a physical/physiological dysfunction. They reiterate throughout their book that three out of four cases of impotence among American males is the result of a physiological condition. Diabetes is the number one cause of impotence. Although Bruce was a diabetic, I was not. The physicians involved in my diagnosis, having determined I was not a diabetic, were not pursuing other physiological causes of the impotence.

Armed with information from this book, I went to yet another urologist in Fresno specializing in male impotence. Once again, I heard the old litany — you're getting older, you have been through a traumatic divorce, etc. At my suggestion, he sent me for a penile doppler test. This ultrasound diagnostic test charts the blood flow in and out of the penis. The test consists of injecting papaverine, a pharmacological preparation which causes an erection, into the penis and then tracking the flow of blood. We had read a great deal about papaverine in the disability literature, since many men with spinal cord injuries use it to produce an erection, enabling them to have intercourse. The ultrasound test was not painful and lasted about thirty minutes. The physician administering the examination told me there was clear evidence that the veins in my penis were not acting normally, a condition known as venus leakage. In other words, blood flowing into my penis was immediately leaked back into my bloodstream, resulting in the loss of the erection. He used the analogy of a sink filling with water with no plug; the water quickly flows out of the sink. This also explained why the Response device did not work.

I experienced mixed emotions about this diagnosis. I was relieved to know my impotence was not psychologically or emotionally induced. However, I was furious about the years wasted in the pursuit of psychological cures for what was clearly a physical problem. I was frightened about the future for us as a couple and for me as a man.

The urologist suggested two alternatives. One was to follow the papaverine injection routine commonly used by men with spinal cord injuries, the other was to go for a penile implant. The problem with penile injections is that the erection they produce can last for four or more hours, sometimes resulting in an emergency trip to the hospital to counteract the effects of the drug. In addition, with repeated injections there is the possibility of scarification of penile tissue. For me, this option meant giving up control of my body. My urologist concurred with my decision to have the penile implant surgery.

Seated comfortably in my urologist's office, Toni and I examined several types of penile implant devices, while he explained the pros and cons of each device. This hands-on experience was helpful in making the final decision. Since my urologist had performed more than 200 of these surgeries during the last few years, I accepted his recommendation of the Mentor Alpha 1. This device consists of a small, hard plastic ball attached to two long, flexible plastic tubes and a small bag containing fluid. The bag is surgically implanted in the abdomen, the tubes are inserted in the penis, and the ball is placed in the scrotum. By squeezing the ball, the fluid is sent from the bag into the tubes, which inflates the penis. To deflate, a ring just above the ball is squeezed, sending the fluid back into the sack. The urologist gave us a demonstration model of the Mentor to take home. At our leisure, we could become familiar with the device and experience inflating and deflating it.

Before making the final decision, we checked on our medical insurance coverage. Fortunately, our medical insurance covered this procedure. We negotiated an agreement with my urological surgeon that he would accept the coverage provided by my insurance as full payment for his services.

Having opted for the surgery and having selected the particular device, we had to decide on whether I would return home the same day or spend the night in the hospital in Fresno. Throughout these deliberations, Toni was with me, and we explored all the options together. Without her understanding and support, the entire process would have been more of a nightmare than it was. Once again, in consultation with my urologist, we decided to have the surgery done on an in-patient basis with me spending the night in the hospital.

On the day of the surgery, I was a nervous wreck because I had not been hospitalized since I had my tonsils taken out at the age of five. We had arranged with friends to keep my guide dog, Kirby, for the day, so Toni could spend time with me in the hospital. All the hospital staff, from the time of admission through the operation, were great and explained every step of the process. The urologist made an incision in the scrotum and positioned the Mentor in its proper place. The operation took about an hour, during which I was under general anesthesia. After the operation, I was kept on intravenous medication until the next morning, and my urine output was carefully measured. I was given a urine bottle and encouraged to go as frequently as possible. The nursing staff were friendly and accommodating. When Toni had to get her guide dog, Ivy, out for relief, a nursing assistant went with her. In the evening, when the friend who was taking care of my dog, Kirby, came to drive Toni home, he brought Kirby in for a short visit. The hospital staff seemed delighted with the well-behaved canine visitors.

When I left the hospital the next morning, I was sore. My testicles were swollen to the size of grapefruits. My penis was tender and swollen. In order to facilitate healing, my penis was left partially inflated, which created a great deal of discomfort and a sense of urgency in urination. My urologist had failed to discuss the after-effects of the surgery. I had imagined I would be healed in a week or two. However, this was not the case. In fact, it took almost three months for all the swelling to go down and for me to feel completely comfortable.

During the recovery period, I saw my urologist several times. The initial visits were not without pain. In order to check the Mentor, he inflated and deflated the device in spite of the swelling. At the time I wondered if all this pain would be worth all the anticipated future pleasure. About a month after the surgery, he told me to inflate and deflate the Mentor on a daily basis to foster healing. Although I followed my doctor's direction totally and was proud of the erections I could produce with the aid of the Mentor, I still feared intercourse. I had experienced impotence for so many years, I feared the device would malfunction. The doctor reassured me I could have orgasms with ejaculation, but for quite a while I was unwilling to take the risk. Three months after the surgery and with considerable trepidation on my part, Toni and I re-initiated our sex life. To our delight and joy, my doctor was right. I could have a satisfactory orgasm with ejaculation. In addition, I could continue to provide pleasure to Toni after ejaculation since my erection was maintained until I deflated the mechanism. After the resumption of our sex life, Toni and I joked that our first sexual intercourse represented a $13,000 investment!

This $13,000 figure consisted of the hospital bill of $9,300, the urologist and his surgical assistant's fee of $3,000, and the anesthesiologist's charge of $700. Of the $9,300 hospital expenses, $4,600 was for the Mentor Alpha device. My medical insurance paid the entire hospital charge and 80% of the doctors' charges. Since my urologist had agreed to accept my insurance payment, the only out-of-pocket expense for me was the $200 that I needed to add to the anesthesiologist's payment.

Although the surgery was painful and the recovery slow, it was worth every moment of pain and discomfort. I now have control over my body, and performance anxiety is a thing of the past. I regret the years wasted in seeking psychological solutions that were inappropriate to my problem.

I owe my greatest debt to Toni, who stayed with me throughout this entire ordeal of my impotence. Without her support, understanding and love, the problem would never have been properly addressed and a solution found. Whenever I was discouraged or whenever we tried a new approach without results, she remained steadfast in her commitment to our relationship. This article, which has been a very difficult one to write, is my tribute to her.

I would be very happy to talk with or correspond with any readers about this issue. My address is: Ed Eames, 3376 North Wishon, Fresno, CA 93704; telephone: (209) 224-0544.

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If you or a friend would like to remember the Diabetics Division of the National Federation of the Blind in your will, you can do so by employing the following language:

"I give, devise, and bequeath unto Diabetics Division of the National Federation of the Blind, 1800 Johnson Street, Baltimore, Maryland 21230, a District of Columbia nonprofit corporation, the sum of $_____" (or "_____ percent of my net estate" or "the following stocks and bonds: _____") to be used for its worthy purposes on behalf of blind persons."

A little knowledge is dangerous

by Eileen V. MacKenzie

Despite media publicity through radio, television, newspapers and magazines, together with our daily contact with the public, and various books written on the problem of impotence, it still horrifies me to think that people are being misdirected and misinformed — but such is the fact.

Take a very recent case that came to our attention via the telephone. A man had been taking testosterone for four years in the hopes his impotence would be successfully treated. Not only did the impotence remain with him, the risks of side effects had not even been brought up in his consultations with his physician. To top it off, he was paying an exorbitant amount of money every month for his treatment, which was limited to the shot.

Take another recent case of a man whose general practitioner more than three years ago told him not to worry, things would work out right for him with patience and time — naturally this did not happen and so he opted for an appointment with a specialist. What was he told — nothing could be done for him!!!

IF YOU ARE A PHYSICIAN TREATING IMPOTENCE IN YOUR PRACTICE, please give that information to physicians in your area — you may save a man and his partner years of hopelessness, helplessness and humiliation as in the above cases — you may save a marriage — you can help.

(*Note:* This article appeared in the Winter 1991 issue of *Impotence Worldwide,* published by Impotence Institute of America. Reprinted with permission.)

The awakening

by Dan Mack

Dan Mack has a positive attitude and maintains an awareness of difficulties experienced by non-diabetics.

With some recent news came a not-so-subtle realization. I felt as though I had hit my thumb with a hammer.

As a diabetic of thirty years, I am blind, nearly deaf, have had a leg amputated, and have undergone a kidney transplant. Although I continually strive to keep a positive outlook, there are times when the burden of my troubles almost becomes too much for me.

Twenty-five years ago when I was living in Nome, Alaska, a friend and I began running around together. We fished, hunted, prospected for gold, rode snow machines, beachcombed and did other things that young persons enjoy doing.

Through the years, as diabetes has taken its toll, my friend has always encouraged me through his letters and phone calls. Lean, active, nonsmoking, non-drinking, he has always been the picture of health. The all-American guy even loves to watch football games. But, recently, in his mid-forties, he had a heart attack. Talk about blowing me away! Man, I was gone! This was not something that was supposed to happen to my healthy friend. This was something that I had subconsciously reserved for myself.

His physicians put a balloon through his arteries, prescribed aspirin and blood thinners, and told him that if he makes it through the next six months, he will probably be okay for a while.

It is too easy to become so overly concerned with ourselves and our state of health that we forget that others also have problems. In relating this, my hope is that you, too, can gain from the lesson that this has taught me. Maybe we are pretty lucky to be in as good of shape as we are — we're surely not the only ones in this world with problems.

(Editor's Note: Thanks, Dan, for giving us something to think about. In a February letter, Dan adds that his friend is doing fine and has returned to work full-time for the Federal Aviation Administration.)

No longer diabetic? Reflections on kidney and pancreas transplantation

(Continued from page 1)

ditioning with a blood transfusion, a low dose of an immunosuppressant drug and some related periodic blood tests. I crossed my fingers and hoped that the transplant would come soon to prevent greater problems.

While waiting for a cab, I threw a few items into my suitcase. I was ready to go by six o'clock, but the cab seemed to take forever. When the cab arrived, I told the driver of my urgent need to get to the airport on time for the flight. I live over thirty miles from LAX and traffic conditions on the 405 freeway are often very bad.

Stopping only at the automatic teller machine for a quick $200.00, we were resolute in our determination to get to the airport on time. I arrived at the ticket counter ten minutes before flight time. The ticket agent informed the gate that I was on my way. I bought my ticket, cleared security, and ran for the gate. I made it!

The surgery was performed that night. With all of the post-surgery tubing and gizmos attached, I woke in the intensive care unit, breathing through a respirator. Over the next forty-eight hours, I experienced extreme pain and swelling from two separate incidents of post-surgical bleeding. I underwent two more surgeries to stop the bleeding. Finally, after a week, the respirator was removed. I was released from the ICU and sent to a room on the transplant floor.

I remained in the hospital for a month, which is about twice as long as normal for this type of surgery. Part of the problem was a surgical wound in my abdomen that was healing at the skin level but not underneath. The wound had to be opened and packed so that it could heal properly.

When I was released from the hospital, I stayed at my sister's place. I was out of the hospital only three days when the daily post-transplant blood test showed that my creatinine level was taking a sharp turn upward. I was readmitted to the hospital where a renal ultrasound and a kidney biopsy were quickly performed. The biopsy report came back showing moderate to severe rejection. I was placed on a week-long program of intravenous antirejection drugs. The rejection episode was brought under control, and I was again released from the hospital a week later. I returned to my sister's place. For the next two weeks a home health care nurse came three times a day to change the dressing. Via the nurse, I continued providing the transplant center with daily blood and urine samples for laboratory testing.

In late August I returned to Los Angeles and went back to work in the second week of September. Now was the time to begin to answer the important questions. What would my life be like after the transplant? Would I be able to return to work and perform well on the job? Would I continue to have setbacks involving my transplanted organs? Would I be able to dispense with the services of a home health care nurse and dress the wound myself so that I could return to work? Would I get stronger? Would some of the side effects of the immunosuppressants, such as tremors and skin eruptions, decrease with lower dosages and time? Would my blood sugar truly stabilize within the normal range? What would life be like with no insulin injections, no insulin reactions, and the ability to delay or even forego meals?

In October, I returned to Minnesota for treatment of an abscess that developed next to my transplanted kidney. That took a little more than a week and, of course, more money for the related transportation expenses. The October infection returned with a vengeance in early December. The bug that first infected the tissues surrounding the transplanted kidney was now in my urinary tract and adversely affecting both my new kidney and pancreas. (Connecting the transplanted pancreas to the bladder enables testing for urine amylase levels, but exposes the transplanted pancreas to urinary tract infections.) This time, I was treated by local physicians and the situation is coming under control. Kidney and pancreas functions are improving and are nearly back to normal. I haven't needed to be hospitalized.

Speaking of infections, I have also contracted a fungal infection commonly called thrush inside my mouth. With our suppressed immune systems, such infections are commonplace among people with transplanted organs. Immediately following my transplant, I was prescribed Nystatin liquid five times a day as a preventative for this type of infection. After a new months, I discontinued the swishing and swallowing of this liquid, but I am now using the medication again and the infection is under control. I just hope that all of these problems with infections will stop. I know that many transplant recipients do not experience such problems. Such problems are new for me; maybe this experience will be short-lived.

It is now the last week of December. Christmas giving was necessarily lean this year because of the transportation-related expenses of my trip to Minnesota in October.

If some of the things I have described have given you reservations concerning kidney or pancreas transplant surgery, let me reassure you that, despite some problems, overall it has been a rewarding experience, and I would do it again if I had to. To be sure, some transplant recipients wish they had never gone through the surgery. Their experience should not be ignored any more than mine. About half of the people in a transplant center are there for post-transplant complications. However, there are a great many more recipients that either never, or minimally, experience post-transplant complications. I have met and worked alongside some of those success stories. Some of them I found within the National Federation of the Blind (NFB) Diabetics Division, and some I found at the transplant center. They were there for nothing more than follow-up studies and annual checkups. These individual successes have been extremely encouraging. I increasingly find that my story is one of success as well.

I am growing stronger, more energetic, and increasingly more active. I am receiving compliments at work for the speed and quality of my work. Once again, I am taking an active part in NFB activities. And I have tackled some long-overdue household tasks. I am pleased with my life and it seems that people are pleased with me.

Now when I speak of my pancreas transplant, a common response is "Then you're no longer diabetic." I have been forced to give this assertion some thought. Despite the fact that I am no longer insulin-dependent, I just can't think of myself as being no longer diabetic. On an emotional level, I have been a diabetic for so long that it is an undeniable part of my identity. On a practical level, the control of diabetic complications is the reason I got the transplant in the first place. Control of diabetic complications is still very much a part of my life. Much of the business of controlling diabetes is found in the development of good habits. Bad habits diminish control. Although the pancreas transplant took away the need for insulin injections and produced continuously normalized blood sugar, it did not remove the need for vigilance in the maintenance of good habits. The insulin injections have been replaced by a host of other drugs, all of which need to be taken on schedule. The testing of blood glucose levels has not been completely eliminated and, in addition, there is now a battery of lab tests which at this point must be performed twice weekly.

I must still be concerned about cardiovascular problems. I must monitor my blood pressure and get an adequate amount of exercise. I must eat a low-fat, high-fiber diet. My new kidney will let me eat more protein, but for some reason it does not tolerate high-potassium foods. Citrus fruits, bananas, melons, tomatoes, and potatoes are not in my meal plans. Some of these requirements would be part of a healthy lifestyle, whether or not I was ever a diabetic. However, diabetes brought me to where I am now, and it continues to be an important part of my life.

Who knows? I could reject either the new kidney or the new pancreas and be forced to again accept a lifestyle that includes dialysis and/or insulin injections. If so, I will accept this turn of events gracefully and wait for the opportunity for another transplant. In the meantime, I am happy with what I have done. I am encouraged by both the already-realized and potential benefits, and I am still a diabetic.

If you are considering a kidney or pancreas transplant, then first admit that it is a scary notion. But so is the alternative. The continued threat of diabetic complications may, for you as it did for me, outweigh the risks associated with pancreas transplantation. If you are experiencing diabetic kidney disease, your choices will eventually involve either transplantation or dialysis. Long-term dialysis is not generally thought to be the preferred alternative for diabetics.

Whether or not you are considering transplantation, you should do as much as you can in the way of living a healthy lifestyle. Stay on your diet. Get plenty of aerobic exercise. If you smoke, stop! If you are administering insulin injections or are using an insulin pump, monitor your blood glucose levels closely and opt for the most effective insulin therapy that you can get. See your doctor routinely. Most of all, keep your spirits up. Life is good, and you can make it very good.

SECURITY EQUALITY OPPORTUNITY NFB

Diabetic men, impotence, and how to prevail

by Ed Bryant

(Continued from page 4)

of impotence can point the way to PREVENTION of strokes, heart attacks, and other life-threatening illnesses. When the cause is psychological, learning the nature of the etiology is the first step to recovery. This is particularly true when fear is the culprit. Discovery that fear has caused the problem is generally all that is needed to overcome the impotence.

RECOGNIZE THAT A PROBLEM EXISTS

Regardless of the cause(s), if a man does not have and/or cannot sustain erections adequate for vaginal penetration over a period of four to five weeks, he should recognize that a problem exists and seek medical help. This persistent inadequacy should not be confused with the normal, occasional bedroom failure. Because erectile dysfunction may be a symptom of an underlying undiscovered disorder, and because it can be treated, the man should not delay seeking medical help. Erectile dysfunction doesn't just go away!

For treatment of impotence, the choice of doctors is most important. Among the best are those practicing at centers that specialize in erectile dysfunction, urologists who subspecialize in the treatment of impotence, and other physicians who are specifically trained in this field. For many people, the first contact in seeking treatment is the family physician. Diabetics will most likely consult with the doctor who treats them for diabetes. Ask that first physician for a referral to a medical professional who is particularly familiar with dysfunction. Local hospital referral services may keep lists of such experts who practice nearby.

VISITING THE DOCTOR

During the initial visit, the doctor who specializes in treating erectile dysfunction will conduct an interview to learn medical and sexual history and perform a thorough physical exam. The doctor will also ask questions designed to lead to the cause(s) of impotence. The physical exam will focus on the neurological, vascular, genitourinary, and endocrine systems because they control nerves, blood vessels, hormones, and penile tissue. A malfunction in any of the systems can cause impotence.

DETERMINING THE CAUSE

After the interview and physical exam, the doctor will determine if the erectile dysfunction is psychological and/or physical in nature. In the absence of any physical findings, and based on indications obtained in the interview, the doctor will determine the cause to be psychological and will refer the man to a qualified health

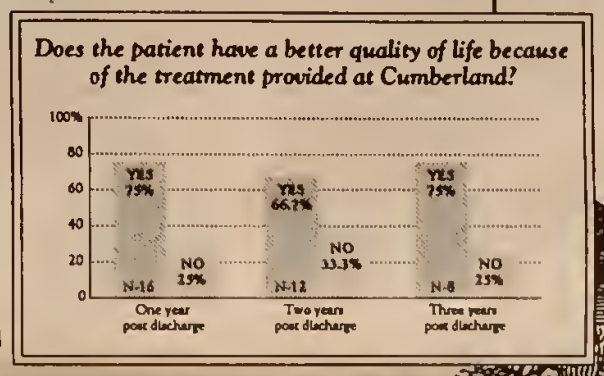
(Continued on page 10)

ADOLESCENTS WITH DIABETES AND NONCOMPLIANT BEHAVIORS

Why Should You Refer Them to the Intensive Inpatient Program at Cumberland Hospital for Children and Adolescents?

RESEARCH SUGGESTS that treatment in the Cumberland Hospital Diabetes Management Program benefits patients for a minimum of three years after discharge—that their diabetes is better controlled and that their social behavior is significantly improved. Treatment at Cumberland often beeaks the cycle of frequent emergency room visits, hospitalizations and school absences.

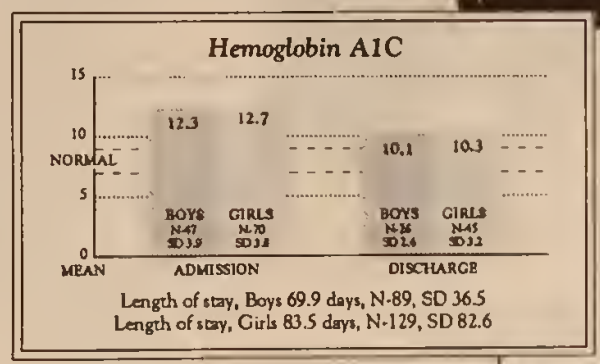
In a survey tabulated in December 1991, parents of patients treated by Cumberland Hospital in 1988, 75 percent said that their child had "a better quality of life because of the treatment provided three years previously by Cumberland Hospital."



The 1991 study continues with the work of a 1989 published report on 80 patients with diabetes treated at Cumberland in 1987 and 1988. In that study of patients one to three years post discharge from Cumberland, 73 percent said the patients are better and 23 percent indicated that they were the same.

CUMBERLAND'S PROGRAM specializes in the difficult-to-manage adolescent with diabetes. Almost all patients have failed in traditional programs—inpatient and outpatient—and have had life-threatening complications despite efforts to properly manage their diabetes.

The December 1991 outcome study examined 221 adolescents with diabetes admitted to the hospital from 1986 through July 1991. A sampling technique was used to target specific subgroups and to evaluate patient progress.



THE YOUNG PEOPLE in the 1991 study were diagnosed with diabetes in preadolescents (boys 8.0 mean years of age, N53, standard deviation 4.1, and girls 8.5 mean years of age, N-77, standard deviation 3.9). The mean age at admission was 15.4 years.

In a 1989 sample of 54 adolescents with diabetes treated at Cumberland between 1986 and 1988, it was found that they averaged 64 days in an acute care hospital during the 12 months prior to treatment at Cumberland and 32 days during the 12 months after treatment at Cumberland.

The 1991 study contacted parents of former patients one, two and three years post treatment at Cumberland to determine the long term benefits. These patients were treated at Cumberland in 1988, 1989 and 1990, and the results are far more favorable that the 1989 published study.

One year post discharge from Cumberland, the patients were hospitalized a mean of 10.8 days (N-15, standard deviation 20.3), two years post discharge and mean of 12.2 (N-13, standard deviation 13.8), and three years post discharge a mean of 7.3 (N-8, standard deviation 9.2).

SCHOOL ATTENDANCE is another good indicator of the success of an adolescent diabetes treatment program. In the 1989 study of 54 patients, patients missed an average of 40 days during the 12 months prior to treatment at Cumberland and 23 days during the 12 months after treatment.

The 1991 study of patients, one, two and three years post treatment was able to obtain limited information on school attendance. According to the study, patients during the 12 months after treatment missed an average of 8.87 days (N-8), and 14 days two years post treatment (N-5). School attendance data on only two patients treated three years post was obtained. They missed 5 and 10 days respectively, of school during their third year after treatment.

CONCLUSION

This study implies that patients benefit from treatment at Cumberland Hospital for a minimum of three years post discharge. This is demonstrated by a number of factors. For more detailed information about this study or any of Cumberland's Inpatient Programs, call the Information Office at 1-800-368-3472.

Cumberland Hospital for Children and Adolescents

New Kent, Virginia

Diabetic men, impotence, and how to prevail

(Continued from page 9)

professional who specializes in treating psychologically induced erectile dysfunction. This may be a psychiatrist, psychologist, sex therapist, or marital counselor.

TREATING PSYCHOLOGICALLY CAUSED IMPOTENCE

To treat psychologically caused impotence it is necessary for the professional to ask specific questions designed to uncover the origin(s). Therapy may consist of home assignments, which include specially designed exercises to increase skills in touching and communication, and thus to help reduce anxiety. Alternative methods of sexual pleasuring without intercourse may be included in the exercises. Information about therapy can be obtained from psychotherapists, sex therapists, counselors, or from one of the many self-help books readily available at most book stores.

COUNSELING DURING THE DIAGNOSTIC TESTS

When the cause of dysfunction is not psychogenic, the doctor, usually a urologist, will begin a round of diagnostic tests. At the same time he/she may recommend consultation with a counselor for the couple because, as previously mentioned, impotence itself can cause psychological problems. Counseling will help both partners cope with the problems the dysfunction has caused in the relationship. Counseling can also help the couple endure the testing procedures and treatments involved, especially those that are invasive.

TREATING IMPOTENCE CAUSED BY MEDICATIONS

As mentioned above, impotence is sometimes a side effect of medications prescribed for other disorders. Such medications include some antihypertensives (diuretics and beta blockers), which control blood pressure, ulcer medications, the heart medication digoxin, antihistamines used for allergy control, antipsychotics, commonly used tranquilizers such as Diazepam, a variety of antianxiety drugs, narcotics including phenobarbital, and a class of medications known as anticholinergics. Tricyclics, used in treating depression, are associated with the disturbance. Many psychoactive drugs cause impotence. However, the particular disorders for which the person is receiving treatment may also contribute to the problem. Over-the-counter medications have been associated with erectile dysfunction. Included are externally applied solutions — eye drops and even nose drops may be linked to the condition. By adjusting the dosage of current medication(s) or by switching to alternates, erectile dysfunction can be improved or alleviated. Any person taking medications should be aware of possible side effects. If side effects aren't known, ask your doctor or pharmacist for information and/or read the package insert that was placed in the manufacturer's container. Consult a physician before discontinuing medications.

DIAGNOSTIC TESTING IN PHYSICALLY CAUSED IMPOTENCE

Laboratory Tests: Urinalysis and blood work are among the diagnostic tests frequently performed during the exam. The blood work will include a fasting blood sugar test to determine the presence of undetected diabetes. The lab can determine abnormal levels of hormones known to be associated with impotence. Elevated levels of a particular hormone, prolactin, can block the action of testosterone (male sex hormone). Although testosterone deficiency/elevated prolactin can lower the sex drive, seldom is such an imbalance the cause of impotence in a diabetic man. Research indicates that diabetes itself does not lower testosterone, and testosterone therapy alone is rarely adequate to alleviate erectile dysfunction.

Tests to Determine the Occurrence of Erection

Ring Type and Snap Gauges: Normal males become erect four or five times during the night. Absence of these erections points to a physical cause for impotence. Three methods of testing can be used to determine if the penis becomes erect during sleep. The conventional test employs a plastic ring which is placed around the penis before going to bed. If the penis becomes sufficiently rigid during the night, the filaments inside the ring will break. The ring was one of the original devices used at home. A newer version is the snap gauge, which is also placed around the penis. The snap gauge has three thin wires which will most likely break during an erection. Both types only indicate if one erection occurred.

NPT: This second method of testing is more accurate in detecting nighttime erections. Known as Nocturnal Penile Tumescence monitoring (NPT), this method employs one of several small electronic devices that can be used at home. The electronic monitor can be strapped to the thigh or placed beside the bed. Electrical leads (wires) are attached to loops placed around the penis to gauge rigidity. However, some home devices cannot detect frequency, duration or quality of nocturnal erections. They recently have been criticized because of failures to detect abnormalities that result in misdiagnoses. In a news release from Johns Hopkins Medical Institutions (October 17, 1991) Charles Brendler, M.D., associate professor of urology and director of the Johns Hopkins Male Sexual Dysfunction Clinic, stated, "In general, take-home devices often are inaccurate and have limited value in determining the cause of impotence."

NPT and Sleep Lab: The third method of determining if erections have occurred also involves NPT monitoring but uses sophisticated equipment in a sleep lab. Leads designed to record electrical output are attached to the head and other parts of the body as well as to the penis. Nocturnal erections occur during periods of the dream phase (REM) of sleep. Wires connected to the head detect the REM phase, while those connected to the penis indicate any increase in both length and circumference. Nocturnal penile erection in the man who is experiencing erectile dysfunction may be an indicator that the origin is psychological. Absence of erections in this carefully monitored test may indicate an organic cause of the disorder. In addition to differentiating between the two kinds of impotence, the sleep lab test measures pulse, blood pressure, brain waves, and other physical responses. Dr. Brendler stated, "A one-night stay at a sleep lab really should be the gold standard that urologists, neurologists, and other health care professionals use to determine the nature of a man's impotence." Although much information can be gathered in a sleep lab, the test is extremely expensive.

Tests to Determine Nerve Function

Vibrational Sensitivity and Nerve Conduction Studies: In the diabetic man, nerve damage (diabetic neuropathy) is a major contributor to erectile dysfunction. This type of dysfunction is slow in onset and many be accompanied by neuropathy in the lower extremities. To evaluate sensory nerves in the penis, an inexpensive, simple, painless procedure, the Skin Vibrational Sensitivity Test, is performed. Diabetic men and alcoholics are those most likely to have a deficit in the sensory nerves. Nerve Conduction Studies can determine damage to other nerves that affect the penis. The urologist may consult with the neurologist before administering these tests.

Tests to Determine Vascular Problems

Penile-Brachial Index and Pulse Volume Recording: Among the several tests that can be used to detect vascular problems, for example blood vessel blockage, these two simple procedures evaluate penile blood pressure and pulse. They can determine where problems with the blood supply originate.

Penile Injection Testing — Papaverine/Doppler Test: This test requires the injection of a medication that relaxes smooth muscles, increases blood flow into the penis and restricts outflow. An erection will occur if the vascular system is functioning. If an erection does not occur, further testing of the system is warranted. The Doppler is a well-known technique that uses penile injection to measure the rate of blood flow into and out of the penis. The same medication — papaverine — commonly used in diagnosis may be used as a therapy, which will be discussed later in this article.

Penile Duplex Ultrasonography: In Penile Duplex Ultrasonography, sound waves are used to create a visual picture, which is scanned to detect abnormalities in the penile artery. This technique is usually performed in conjunction with penile injection testing.

Penile Injection Testing — Dynamic Infusion Cavernosometry (DICC): With vascular X-rays, the most definitive technique for determining problems in the penile blood vessels is called Dynamic Infusion Cavernosometry. This test measures changes in fluid pressure during erection produced by injecting the muscle relaxant previously discussed. These X-rays are used to confirm findings and to pinpoint locations of vascular problems.

TWO SCHOOLS OF THOUGHT REGARDING TESTING

Medical professionals disagree about testing for physically caused impotence. One school of thought holds that the exact physical origin should be identified and located; this requires extensive and expensive testing. The other school first rules out hormonal disturbances as a cause and then makes little further attempt to pinpoint the source and location of impotence. Diagnosis involves attention to the neurologic and vascular systems. The nature of physically caused dysfunction is obvious in men with serious health problems such as any vascular disorder, diabetes, or injury. This group holds that treatment does not depend on how much money you spend or how much diagnostic testing occurs — when all is said and done, in most patients with significant physical causes, such as diabetes, the types of treatments remain the same.

TREATMENT OPTIONS FOR PHYSICALLY CAUSED ERECTILE DYSFUNCTION

Because much knowledge has been gained in recent years about the causes and treatments of erectile dysfunction, impotent men should be aware of their various treatment options. Surgery is no longer the only option. Recently, nonsurgical techniques and theraples have been used with much success. Based on the cause, physicians should objectively present ALL treatment modalities. The man's personal preference — and that of his partner — are vital in the choice of treatment. For the purpose of this discussion I've divided treatments into three categories: medications, external mechanical devices, and surgery.

Medications

Treatment for Hormonal Imbalances: In the case of low testosterone, therapy may consist of a trial of testosterone injections. As I mentioned before, a low level of this hormone is rarely the cause of impotence. This form of therapy may aggravate pre-existing prostate cancer. In addition, men with a history of heart, kidney, or liver disease should not undergo testosterone therapy. When an elevated prolactin level is cited as the primary source, erectile dysfunction can usually be corrected with medication. An elevated level of this hormone is responsible for only 2 to 3 percent of impotence cases.

External Vasodilators Improve Blood Flow: When diagnosis indicates a problem in the vascular system, particularly arterial insufficiency, externally applied vasodilators can be used to dilate arteries, which increases blood flow into the penis. One such medication is nitroglycerine ointment. Commonly used in treatment of high blood pressure and associated heart disease, the ointment is applied to the penis in cases of dysfunction to increase penile arterial flow, which should improve erections. The most notable side effect is that is may cause headaches in the female partner because it is absorbed into the bloodstream through the vagina. To prevent this the man should use a condom. Another topically applied vasodilator, minoxidil, was found to be more effective than nitroglycerine cream with fewer side effects. These findings were published in the July 1991 Issue of *The Journal of Urology*. Minoxidil is in the experimental stage of development. Although some cases of erectile dysfunction respond well to this kind of therapy, the effectiveness of vasodilator products has not yet been determined by the scientific community.

Yohimbine Therapy Shows Promise: Yohimbine medication comes from the bark of a tree that grows in Africa and India. The extract, an aphrodisiac and folk remedy long used for sexual stimulation and impotence has proved effective in some cases of impotence. It is not known exactly how the medication works, but it seems to affect the central nervous system by suppressing nerves that normally restrict erection. It's thought that yohimbine may also increase libido — desire — in some men. The few side effects of yohimbine tablets can be easily alleviated. Many doctors prescribe this therapy for cases of very mild, physically caused dysfunction or for psychological impotence. This therapy does have merit and should be considered before more expensive, invasive procedures are used.

Papaverine Injection Therapy: In the publication *Impotence Worldwide,* (volume 7, number 1, Winter 1991) Myron I. Murdock, M.D., wrote, "Approximately 250,000 men in this country are chronically using self-injection programs of papaverine or papaverine and Regitine."

Other sources report that injection therapy has an estimated 80 percent rate of success. As I mentioned in the section regarding penile injection testing, the injected medication produces an erection by relaxing certain muscles, increasing blood flow into the penis and restricting outflow. This therapy does have disadvantages, such as risks of infection, pain, and scarring — fibrosis — in the penis, and may create "priapism," a prolonged, painful erection that requires immediate medical attention.

In the recent past, papaverine — the same medication used for testing — has been widely used in this therapy. Even though it is effective, papaverine is known to cause priapism.

Drug Combination Injection Therapy: Newer therapies using a combination of drugs have been developed and are proving to have fewer disadvantages and side effects. For example, prostaglandin E-1 used alone has about a 30 percent pain rate, according to Alan H. Bennett, M.D., chairman of the urology department, Albany (New York) Medical Center. When prostaglandin E-1 is used in combination with papaverine, and another drug, Phentolamine, the rate of pain diminishes greatly. "Less than 5 percent of patients have an awareness of discomfort," stated Dr. Bennett. The combination drug-injection therapy also reduces the chance of priapism. Dr. Bennett said, "There is a chance of complication. Prolonged erections don't happen as often with the three-drug mixture. But prolonged erections are very easily reversed providing a doctor is seen within four to six hours." It appears that drug combination therapy may also reduce fibrosis. Dr. Bennett commented, "With the new combination, we don't think we're going to see as much fibrosis. . . . I haven't seen any in my practice." Commenting further, Dr. Bennett said that fibrosis was common in older treatments that used high volume solutions. Regarding cost, the doctor said, "It depends on where you buy it, obviously, but it shouldn't cost more than $2.50 an injection."

As stated above, in most cases the pain is minimal. Penile injection therapy utilizes the same size needle and syringe that many diabetics use every day.

In the publication *Impotence Worldwide,* Dr. Myron Murdock stated, "In summary, pharmacologic self-injection programs with intracorporeal drugs are excellent ways of handling male impotence."

External Mechanical Devices

The second category of treating erectile dysfunction includes external vacuum therapies using noninvasive external mechanical devices that produce painless erections by causing blood to flow into the penis while constricting outflow of blood. In this respect, such a device imitates the natural erection which can be achieved in about thirty seconds. The device does not interfere with orgasmic experience. External vacuum therapy mechanisms are approximately 90 percent successful in causing and sustaining an adequate erection. All devices are portable. They currently cost about $325-$400, but are covered under most insurance plans. Two types of devices are available.

Vacuum Constriction Device: One type is known as a vacuum constriction device. It consists of a vacuum cylinder, various sizes of tension rings, and a hand-operated vacuum pump. Some are battery operated, making it easier to operate for someone who has arthritis. The penis is placed in a cylinder to which a tension ring is attached. Air is evacuated from the cylinder using a hand pump, creating a vacuum, which produces the erection. The cylinder is removed, leaving the tension ring at the base of the penis to maintain the erection. Such devices are not available without a prescription. Most insurance companies provide coverage for this type of mechanism.

These vacuum therapy devices have a few minor disadvantages. It is necessary to interrupt foreplay to use them. THE TENSION RING MUST BE REMOVED AFTER SUSTAINING THE ERECTION FOR THIRTY MINUTES, TO PREVENT PENILE DAMAGE. It is essential to use the correct-size tension ring. The user is cautioned against falling asleep while wearing these devices. Harmless bruising may occur. Although considered to be basically painfree, initial use may produce some soreness. Such devices may be unsuitable for men with certain disorders related to blood clotting. In general, though, vacuum constriction devices are successful in management of long-term impotence and continue to be improved.

Vacuum/Non-Constriction Device: The second kind of external mechanical device operates with a different method of maintaining the blood flow once an erection has been achieved. The erection is created in a manner similar to that of the devices previously described. However, this method does not restrict blood flow out of the penis. The increased blood flow causing the erection is constantly maintained by negative air pressure inside a condom-like housing worn over the penis. Because this device does not interfere with circulation, the man can maintain the erection for as long as desired. For the same reason, no harm can occur to the penis. Also as in a condom, the ejaculate remains inside. It can be easily cleaned with soapy water.

Disadvantages of this device include having to wear the condom-like unit during intercourse. It is slightly thicker than a condom and some men experience a loss of sensitivity a bit greater than that experienced when wearing a condom. This system will almost invariably produce an erection. Choice of external vacuum devices depends on personal preference.

Surgical Treatments

In this section, I'll discuss surgical treatment options for erectile dysfunction. Surgery should be considered only after all other treatment modalities have proved unsatisfactory. Troy A. Burns, M.D., of the Diagnostic Center for Men in Olathe, Kansas, agreed. "I usually consider implant surgery as a last resort if other therapies don't work."

In addition to being the most expensive option, surgery has risks, as does any invasive process. Surgery has provided effective remedies in many cases of erectile dysfunction, but it is not an appropriate treatment for everyone. Of the two kinds of surgery performed, one involves implantation of a penile prosthesis; the other is dedicated to vascular reconstruction. Only 5 percent of impotent men may benefit from vascular surgery. Expert opinion about surgical implants has changed during recent years. Five years ago, surgery was the standard suggested for the majority of diabetic men experiencing erectile dysfunction. However, the latest consensus of opinion indicates surgery is no longer being widely recommended to diabetics. Stephen Weinstein, M.D., associate professor of urology at the University of Missouri Columbia Hospital and Clinics,

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Diabetic men, impotence, and how to prevail

(Continued from page 11)

said, "For patients with diabetes who have impotence, regardless of the cause, the bottom line is that there is always a solution and it doesn't have to involve surgery." Many other less-invasive and less-expensive options work quite well for most men, including diabetics. Even though surgery is 90 percent effective, it is expensive in both monetary and human terms.

Companies that market prosthetic devices sell only to hospitals and physicians and will not provide the selling price to consumers. Through research I have found that the malleable prostheses cost about $1,200 and inflatable devices cost about $3,500. If the man elected to undergo surgery and fees were totaled (surgical, operating room, and the markup on the prosthesis), the cost would be about $8,000 for the malleable and about $12,000 for the inflatable device. These prices reflect rates in central Missouri and should not be considered national averages. Nonetheless, surgery is an available option for impotent men. The decision to have or not have surgery is one that should be made by the man and his sexual partner.

Penile Surgery: The main risk associated with this kind of surgery is infection. Although every attempt is made during the procedure itself to prevent infection, it can develop and may lead to the removal of the prosthesis. Most men are able to avoid infection and it actually occurs in only 3 out of 1,000 cases. As is to be expected, as with all invasive procedures there may be some pain, bleeding, and scarring. I also note that the device itself might fail to work properly and may have to be removed. If for some reason the prosthesis or parts become dislocated, surgical removal may also be necessary. With a general success rate of about 90 percent, any of the devices will restore erections, but they will not affect sexual desire, ejaculation, or orgasm. All implants may alter or injure the erectile bodies.

Prostheses: Each has advantages and disadvantages. Currently about 17 different types of penile prostheses are available. For purposes of this discussion, I've divided the prostheses into three categories: rods, fully inflatable prostheses and self-contained prostheses.

Semi-Rigid or Malleable Rods: These simple devices have the fewest complications and are the least expensive of all. The main disadvantage is that the penis remains constantly erect, which may cause problems with concealment. The semi-rigid type consists of two silicone rods which are implanted into the shaft of the penis. The malleable version contains flexible cylinders that can be bent for intercourse and for easier concealment. The malleable version is probably the preference of men using these kinds of prostheses.

Fully Inflatable Prostheses: These prostheses are complicated mechanical devices that imitate the natural process of erection. Some sources believe that these devices provide the best overall results of all prosthetic implants. Parts include two inflatable balloon cylinders, which are inserted surgically in the penis, a small pumping mechanism, implanted in the scrotum, a storage unit or reservoir for fluid, placed in the lower abdomen or in the scrotum, and connecting tubing. Squeezing the pump bulb causes fluid to leave the reservoir and flow into the cylinders in the shaft, causing the penis to expand in girth and to become firm and erect. When erection is no longer desired, a valve on the pump is pressed, releasing the fluid to return to the reservoir. The penis becomes flaccid. The disadvantages include risk of mechanical breakdown and/or leakage of the fluid. Fortunately, mechanical problems occur in only 3 percent of cases in the first five years after surgery. The inflatable bal-

loon cylinders can buckle, tear, or break. Fully inflatable devices are the most expensive of the three categories due to the more complicated surgery necessary for implanting the parts. Fully inflatable implants are natural in appearance and because the penis is flaccid when erection is not desired, there is no problem with concealment. The man controls the erection.

Self-Contained Single Unit Prostheses: Consisting of a single-rod unit that holds the entire mechanism, these devices are implanted within the penis. When erection is desired, the unit is activated by either squeezing or bending, depending on which of the two types of self-contained prosthesis is used. In this manner, these prostheses also imitate natural erections. None of these devices increase penile width or girth. Some of the mechanical types have been known to fail during intercourse; the inflatable device can sometimes be difficult to operate. The two types vary in methods used to produce an erection. The inflatable self-contained unit uses a hydraulic (fluid) system in much the same way as devices in the fully inflatable category. The main difference is that the inflatable self-contained device is, as the name states, self-contained. The inflation mechanism, fluid reservoir, valves, and balloon are all located inside the rod. Erection is attained by squeezing. The second type of self-contained single unit prosthesis, the mechanical self-contained, uses a mechanical instead of hydraulic means to create erection. Bending the device tightens a cable that is strung with small plastic blocks. When pressed together, the blocks produce the required firmness in the penis.

SOME THOUGHTS ABOUT PENILE IMPLANTS

All penile implants will produce erections suitable for intercourse. When decisions are being made regarding the kind of surgery, other factors should be considered. According to Bruce A. MacKenzie in *Impotence Worldwide* (volume 7, number 2, Spring 1991), purpose is only one of several elements considered when selecting an implant. MacKenzie wrote, "To those who wish to simulate nature to the furthest extent — then a fully inflatable would be their choice; for those who want something relatively simple, ready to use, lower cost, one day less in the hospital — their choice would be the hinged or malleable; to those who want a compromise between the two — a hybrid — they would choose a self-contained; and for those who want the least expensive (low end of the line) — the semi-rigid would fit the bill." These are a few of the factors used in selection.

An additional factor to note is the use of silicone in the implants. Currently, silicone gel breast implants have come under scrutiny. A large manufacturer of prosthetic devices claims that penile implants use a solid silicone elastomer, which differs significantly from silicone gel in the breast implants reported to produce leakage and complications. Although the silicone used in prosthetic devices appears not to have harmful side effects, prospective recipients should discuss the matter with their physicians.

Vascular Reconstructive Surgery for Impotence: Vascular surgery is a procedure that uses highly sophisticated techniques and equipment to physically correct the underlying causes of impotence in the penis. The surgical correction may be directed toward reconstruction of the arterial blood supply or removal of veins when the cause is due to leakage. Only 5 percent of men with erectile dysfunction have surgically treatable impotence. Sixty percent of the men who undergo this treatment can produce natural and normal erections. Unsuccessful surgery does not prevent the use of other options. Men considering this kind of treatment should understand that there is a high rate of relapse. Vascular surgery is incredibly expensive. Complications may include infection, numbness, scarring which can cause penile deformities, painful erections and other abnormalities.

INSURANCE

Most internal and external devices are covered by insurance carriers. The basic 80 percent Medicare payment is usually available when one has the proper documentation. Some third party insurance carriers cover impotence therapy products. However, you should check for specific restrictions that may apply.

YOU DON'T HAVE TO SUFFER IN SILENCE

In summary, sexuality is an important part in the life of every human. It is an integral fiber woven into an person's emotional, physical, and mental well-being. Sexuality contributes much to the quality of life. When quality of life is affected by erectile dysfunction, the man should seek help by communicating with a physician, preferably a carefully chosen specialist. The man should not wait for his doctor to inquire about sexual functioning. IMPOTENCE IS TREATABLE. Dr. Weinstein commented, "There's no reason men experiencing erectile dysfunction have to retire from sexual activity when the solutions are so simple these days." His statement addresses all men including diabetics. Remember that 90 percent of all cases of impotence are physical; in diabetic men in particular, the cause is almost always physical. The man should discuss the problem with his partner-spouse, as she is equally affected by his condition. She should be included during the entire treatment process. Although the subject may be difficult to talk about, the woman is integral to the relationship and deserves complete honesty. Marriages and other relationships are based on solid foundations only when couples consider each other's feelings, so COMMUNICATE WITH YOUR PARTNER.

COMPANIES THAT MARKET IMPOTENCE THERAPY SYSTEMS

Pos-T-Vac, P.O. Box 1436, Dodge City, KS 67801; telephone toll-free: 1-800-627-7434. They offer vacuum constriction devices.

Osbon Medical Systems, P.O. Drawer 1478, Augusta, GA 30903-1478; telephone toll-free 1-800-438-8592. They offer vacuum constriction devices.

Synergist Limited, 6910 Fannin, Suite 304N, Houston, TX 77030; telephone toll-free: 1-800-422-9005. They offer a vacuum non-constriction device.

Dacomed Corporation, 1701 East 79th Street, Minneapolis, MN 55425; telephone toll-free: 1-800-328-1103. They offer a vacuum constriction de-

vice as well as prosthetic devices.

American Medical Systems, P.O. Box 9, Dept. 800, Minneapolis, MN 55440; telephone toll-free: 1-800-843-4315. They offer numerous prosthetic devices.

Mentor Corporation, 5425 Hollister Avenue, Santa Barbara, CA 93111; telephone toll-free: 1-800-235-5731. They offer a vacuum constriction as well as prosthetic devices.

RESOURCE LIST OF INFORMATION AND SERVICES

Sexual Dysfunction/Male Impotence Committee of the Diabetics Division of the National Federation of the Blind, Chairman, Bill Parker, Lafayette Tower, 4601 Mayflower Road, Apt. 2D, Norfolk, VA 23508; telephone: (804) 623-1638.

Resource Library Committee of the Diabetics Division of the National Federation of the Blind, Chairwoman, Cheryl McCaslin, 7717 Eastern Ave., Apt. B, Dallas, TX 75209; telephone (214) 352-4974. For a free copy of "Diabetic Men, Impotence, and How to Prevail" send a self-addressed stamped envelope.

National Kidney and Urologic Diseases Information Clearinghouse, Box NKUDIC, 9000 Rockville Pike, Bethesda, MD 20892. They publish a comprehensive bibliography on impotence, free upon request: "Impotence: Patient and Professional Materials."

Impotence Institute of America, 2020 Pennsylvania Avenue, N.W. Suite 292, Washington, DC 20006; telephone: (301) 577-0650.

Impotents Anonymous (IA), P.O. Box 5299, Maryville, TN 37802. For a brochure, send $1 plus a self-addressed stamped envelope.

American Association of Sex Educators, Counselors, and Therapists (AASECT), 435 North Michigan Avenue, Suite 1717, Chicago, IL 60611. For a list of certified AASECT members in your state send a self-addressed stamped envelope.

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Dear friends

The Diabetes Treatment Center of Houston, Texas asked its past and present patients to comment on measures that family members or friends can take to better support the person with diabetes. Only minor editing was made to the following responses.

If you have comments that would help others better understand diabetes, please send them to the Voice editor.

• • • Diabetes is a serious disease, causing damage to kidneys, feet, all parts of my body, without external signs — I may look fine. But I must eat correctly, on a schedule, and take my insulin on time. I cannot participate in family gatherings centered around food (i.e. Thanksgiving) without a great deal of support and without willpower on my part. Diabetes is not caused by my eating too much chocolate pie growing up. It is a disease of the blood vessels and pancreas.

• • • Diabetes is not my whole life! I worry about it sure, what diabetic doesn't — either consciously or subconsciously, but I do not harp on it. It is a very personal disease that requires a lot of responsibility. If I need a sounding board, please be there for me, but don't press for information. I have so much going on in my life that I need to sort out. Diabetes is number one in my life, but it is one in a list of things. So, give me a chance to live life.

• • • Stop asking if I want certain foods that you know I cannot eat. Stop telling me it won't hurt me to eat just a bit when I know it will. It's hard enough not to eat certain foods anyway.

• • • Please don't encourage me to occasionally eat sweets by saying "only a little bit won't hurt you." As an ex-chocoholic, there is no such thing as a little bit.

Clot-buster drug could save thousands more lives

Clot-dissolving drugs have been proven as lifesavers for nearly a decade.

Thousands of heart attack patients could be saved if strict guidelines limiting the use of these powerful drugs were broadened, according to a study by Beaumont Hospital cardiologists published in the *Annals of Internal Medicine*.

Of 1,461 heart attack patients treated at the Royal Oak, Michigan hospital during a two-year period, 85 percent were ruled ineligible for clot-dissolvers under accepted guidelines for administering the drugs. In-hospital mortality for these patients was five times higher than for patients who qualified for "clot-busters."

According to the researchers, 50 to 60 percent of these patients could have been safely treated with the drugs versus the sixteen percent eligible under the guidelines.

Patients excluded from clot-dissolving therapy tended to be older, were more often women, having histories of heart attacks, hypertension, strokes or chronic angina, or came to the hospital more than four hours after the onset of chest pains.

About 1.5 million Americans suffer from heart attacks each year.

(Note: This article appeared September 11, 1991 in *Speaking of Health*, published by William Beaumont Hospital, Royal Oak, Michigan.)

Pregnant women can work out gestational diabetes

New findings show that specialized exercise therapy can cure a woman of gestational diabetes before she gives birth, and may even help prevent the onset of the pregnancy-related disease.

Until recently, it was believed that diabetes brought on by pregnancy could only be treated, not cured. The disease almost always clears up immediately after pregnancy, but new findings indicate that six weeks of exercise may cure the disease, decreasing the risk of complications.

The findings were announced recently by Dr. Lois Javonovic-Peterson, former chair of the Diabetes and Pregnancy Council of the American Diabetes Association.

The research found that a rigorous upper-body exercise regimen with a diet low in carbohydrates and sugar was successful.

Women in the study participated in three, 30-minute, upper-body workouts per week. The exercise was performed on arm ergometers — devices resembling bicycle pedals that work the arms.

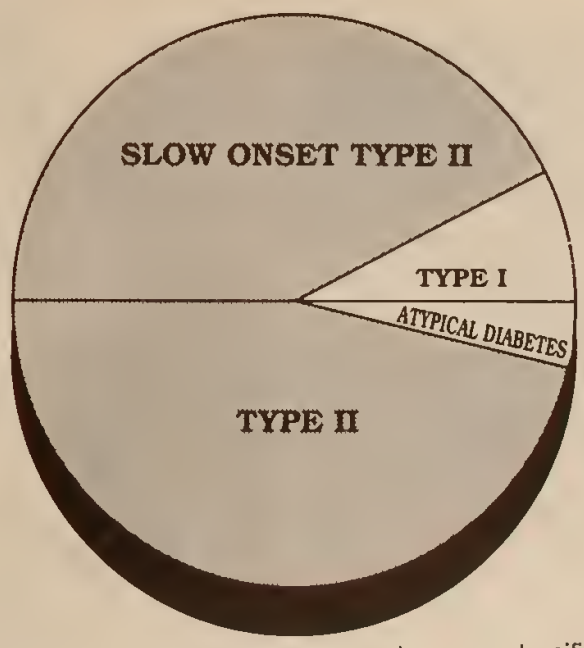
(*Note:* This article appeared November 2, 1991 in the *News Press*, North Fort Myers, FL.)

Diabetes has many types, characteristics

by Nicolas N. Abourizk, MD

Dr. Nicolas N. Abourizk is Director of the Diabetes Care Center at St. Francis Hospital and Medical Center in Hartford, Connecticut. He is also an assistant professor at the University of Connecticut School of Medicine in Farmington

What type of diabetes do you have?
Is it Type I, Type II or something in between?



For decades, diabetes specialists have noted that there is a "mild" as well as a "severe" form of diabetes, and also a "juvenile" as well as an "adult" type.

Although they believed the disease was associated with low (or no) insulin levels in the blood, they found (to their surprise) that while some diabetics had low blood insulin levels, others had above-normal blood insulin levels. These findings led them to believe that diabetes could be caused either by: 1) lack of insulin itself, or 2) lack of a response to existing insulin.

By the end of the 1970s, scientists agreed on new classifications for diabetes:

- Type I, insulin-dependent diabetes, where insulin is lacking and the person depends on daily insulin injections for survival.
- Type II, noninsulin-dependent diabetes, where there is a lack of response to existing insulin, and diet and exercise are the primary treatments.

(Scientists also listed rare, genetic and hormonal diseases as rare

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Diabetes has many types, characteristics

(Continued from page 13)

causes of diabetes.)

Many scientists believed that treatment plans could be simplified: for Type I diabetes — daily insulin injections; for Type II diabetes — diet and exercise.

Unfortunately, this belief was incorrect.

As you know, Type I treatment not only requires insulin injections, it also requires diet, exercise and monitoring with continuing adjustment to maintain good blood glucose control.

Type II basic treatment is even more complex. Diet, exercise, oral medication, insulin injections, monitoring and adjustments are some of the many factors found to be required for proper control.

What does this mean for you?

Based on research conducted during the past decade, scientists have reached these conclusions:

1 Diabetes has many changing phases in each person.

2 Many persons have diabetes that does not fit either a Type I or Type II classification.

TYPE I. Many years before Type I diabetes is diagnosed, changes take place in a person's blood.

Antibodies are produced and appear in the bloodstream, and these antibodies attack and destroy the insulin-producing beta cells within the person's pancreas gland. During these early years, the person does not show any symptoms of diabetes. Eventually, insulin production falls below the level required by the body to function effectively, and the symptoms of diabetes becomes apparent.

After diagnosis, the required treatment is daily insulin injections. Over time, however, there is a gradual increase in the body's resistance to this injected insulin.

TYPE II. For years before diagnosis, the person produces above-normal amounts of insulin but does not feel any of the signs and symptoms of diabetes. As time passes, the need to produce ever-increasing amounts of insulin exhausts the insulin-producing ability of the cells within the pancreas. Blood glucose levels begin to go out of the normal range and get progressively worse.

For some people, weight loss and exercise are the first line of treatment at this stage.

But for others, weight loss and exercise don't work to control blood glucose, and use of one of the oral antidiabetes medications is needed to maintain control.

For still others with Type II, daily insulin injections are prescribed to improve and maintain control because of their decreasing ability to produce enough usable insulin.

SLOW ONSET TYPE I. Some people with Type II diabetes seem to do well, for many years, on the standard treatment (diet, exercise and orals). But gradually, blood glucose control worsens and the oral medication fails to work.

At this time, insulin injections are needed. What behaved like Type II diabetes years ago has entered a phase of insulin requirements and may even become Type I diabetes.

Research has shown that some people who "fail" on oral agents have a type of diabetes that is not Type II, but is slow onset Type I.

Analysis of their blood shows the presence of the same antibodies that are found in youngsters with Type I diabetes.

ATYPICAL DIABETES. Almost one-third of adults with diabetes do not clearly fit into the typical Type I or Type II categories.

Some of these people have Type II that is slowly changing to Type I (see previous section). Still others have diabetes that is related to scarring in the pancreas as the result of malnutrition or starvation.

Although Type I diabetes typically occurs in youths, it is also diagnosed in adults (and has different characteristics in adults than it does in children).

Individualized Approach

One thing to remember from the information that scientists have discovered about diabetes: your diabetes management plan is designed for your own type of disease and your own lifestyle.

Your plan, no doubt, differs from the ones prescribed for a friend, neighbor or relative. That's nothing to be concerned about.

Another thing to remember is that diabetes changes with the passage of time, and your management plan will need "tune-ups" (just like your auto) on a regular basis. What worked for you a few years ago may not work now.

That's why regular visits to your diabetes doctor are so important. Your doctor can help you make adjustments in your diet, exercise and medication that reflect the changes in your diabetes, your body and your lifestyle.

(*Note:* This article appeared in the September-October 1991 issue of *Diabetes in the News,* published by the Ames Center for Diabetes Education. Reprinted with permission.)

Ronald James, M.D., long-term insulin-dependent diabetic, directs Midwest Diabetes Treatment and Education Center, Columbia, Mo. Dr. James is also the Medical Director of the Central Missouri Diabetic Children's Camp, Inc.

Ask Dr. James

by Ronald James, M.D.

(Note: If you have any questions for Dr. James, please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.)

I have trouble keeping my diet and insulin regimen on schedule. Can you suggest a possible solution?

Your problem of keeping on schedule is not unique to you nor is it unique to diabetics. Some people with all types of conditions and from all walks of life have this problem. There is no magic answer. A diabetic simply has to set priorities and develop a plan as to when meals and snacks will be eaten and insulin injections taken. For example, if scheduling is made difficult by an extended period of time between meals, perhaps this could be handled by taking more than one snack between these particular meals. If you have trouble remembering (perhaps because of being busy), you might use some type of an alarm system or ask a friend, relative, or associate near you to remind you. If one is not at home at meal time or injection time, the food or insulin and equipment as well as blood glucose monitors can be taken most places one goes.

Diabetics often complain they cannot follow a schedule because of the other things they are doing. They need to remember that in order to be able to do these other things for a long period of time, they must take good care of their diabetes. It is a matter of priority.

For the most part, being on schedule is a matter of being (1) willing to follow a schedule and (2) ambitious enough to make the necessary effort. There are no good excuses not to do so.

When a family member offers me food that I should not eat, is there a gracious way of refusing? Often family members and friends do not understand my special diet.

You are quiet correct in stating that "often family members and friends do not understand your special diet." What is a gracious (or acceptable) way of refusing foods you should not eat will vary from one family, family member or friend to another and may depend to a great extent on how you feel about yourself and about having diabetes. Therefore, there is no one way that is best to handle all circumstances. In some cases your friends' or relatives' ignorance about diabetes may be so profound and they may be so adamant about your eating that there is no gracious way of refusing. In such cases you may need to be just as adamant about refusing in order to protect your health.

As a diabetic you should be quite knowledgeable about your condition and should not need to be defensive. If your friends or relatives are reasonable, they will be willing to listen to you. This should then be taken as a golden opportunity to inform them about diabetes as well as why you cannot eat certain foods. In the future they may face many other people with this condition and the knowledge you impart to them may make life a little better for all concerned. Always remember to be courteous and never forget to say "thank you" for the offer. I feel you should never be expected to sacrifice good diabetes care because of someone's lack of understanding.

Covering the gaps in Medicare

New rules to protect consumers

by Sal Nuccio

Reprinted from *Better Homes Gardens® magazine.*

Medicare provides basic health insurance coverage for people who are aged 65 and older or have certain disabilities. Yet Medicare protection is far from complete, especially in these days of soaring health-care expenditures.

To supplement coverage, insurance companies have long offered so-called Medigap policies — at annual prices ranging from $650 to $1,200, $1,500, or more. But finding the right contract at the right price has been difficult and especially confusing for the elderly. The market is full of complex policies that defy comparison. Also, sales tactics can be misleading, if not abusive.

More consumer protection. To help customers make informed choices, Congress recently imposed tougher standards for Medigap insurers. The heart of the legislation requires the companies to market standardized policies so that customers can compare competitive products more easily.

Ten standard policies, including a basic core-benefit contract, should be available next year. Each Medigap insurer must offer the basic policy, and may choose any of nine other contracts offering varied benefits. (Generally, the more the contracts fill the gaps in Medicare, the more expensive the policy.)

To ease comparisons with other policies and with Medicare's benefits and gaps, insurers also must provide potential buyers with outlines of policy coverage. All outlines must use uniform language.

Under the new laws, states may apply for federal grants to set up or expand free counseling programs on Medicare, Medicaid, and other health-care issues. However, as we went to press, Congress had not yet appropriated the $10 million that was authorized for this purpose. About 12 states already offer counseling.

OTHER SAFEGUARDS

Additional provisions (and effective dates) under the new law include:

- **Prevention of duplication:** Agents may not sell a Medigap policy to anyone who has one, unless the buyer provides written intention to drop the old policy. (1992)
- **No waiting periods** or preexisting conditions are allowed when one Medigap policy is bought to replace another. (November 1991)
- **Guaranteed renewability:** A policy may be cancelled or not renewed only if the policyholder did not pay for it, or lied. (November 1991)
- **Medigap by mail:** Direct-marketed policies must be approved by states in which they're sold, giving buyers state protection. (July 1991)
- **Group policies:** When a contract is terminated, group participants must be offered conversion to individual policies. (1992)
- **Open enrollment:** The insurance company must offer coverage to individuals, regardless of medical history, for a six-month period after they turn 65. (Don't miss this deadline.) The same applies to the working-aged for the six months after they enroll in Medicare's Part B. Higher prices cannot be charged for this advantage. (November 1991)
- **Loss ratios:** Insurers must pay at least 65 cents in benefits for each premium dollar received on individual

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While Medicare pays for a large part of your health care, medical bills could overwhelm you unless you own a supplemental — or Medigap — policy. To help you compare policies and evaluate costs, the following chart briefly describes Medicare's major benefits and payments and the gaps for which you would be responsible. Your social security office has details.

Note: Part A provides hospital coverage. The optional Part B (currently costing $29.90 a month) provides certain other medical coverages.

MEDICARE PART A — Coverage for each benefit period (1)

Benefit	Medicare payment	Gap in coverage (2)
Hospitalization		
First 60 days	all but ...	first $628
61st to 90th day	all but ...	$157 a day
91st to 150th day (3)	all but ...	$314 a day
Beyond 150 days	nothing	all costs
Approved skilled nursing facility		
First 20 days	all	none
Next 80 days	all but ...	$78.50 a day
Beyond 100 days	nothing	all costs
Home health care		
Medical services	all	none
Durable medical equipment	80% of approved amount	20%
Hospice care	all but ...	limited cost sharing
Blood (per calendar year)	all but ...	first three pints

MEDICARE PART B — Coverage for each calendar year

Benefit	Medicare payment	Gap in coverage
(Deductible)		You pay first $100 of year's cost of covered services
Doctor's & other medical services	80% of approved amounts	20%, plus excess charges (4)
Laboratory services	all	none
Home health care	... The same as under Part A ...	
Outpatient hospital treatment	80% of approved amount	20%
Blood	80% of approved amount after third pint	First three pints and 20% of balance

(1) A Part A benefit period begins with initial hospitalization, and ends after you've been discharged and haven't received skilled care in any other facility for 60 days in a row.

(2) In addition to gaps listed, Medicare doesn't pay for private-duty nursing, most outpatient drugs, most overseas care, custodial nursing-home care, checkups, cosmetic surgery, and dental, eye, and foot care.

(3) A lifetime reserve of 60 days may be used. Not renewable.

(4) Physicians not accepting Medicare allowances cannot exceed Medicare-approved charges by more than 40 percent in 1991 (20 percent in 1992, 15 in 1993) for medical evaluation and management service, and 25 percent for other covered services. More stringent laws in several states supersede federal restrictions; check your state's insurance commission.

Letters to the editor

Grandview, Missouri
September 1991

Ed Bryant, Editor
Voice of the Diabetic

Dear Sir:

What a great paper! I really enjoyed every article. It was so informative and interesting!

I am a recent diabetic and my mom was given a copy of your paper by her eye doctor. She brought it home to me and I hungrily digested it all. It was just what the doctor ordered! I'm very interested in learning all I can about my newfound condition.

I want to be a member of The Diabetics Division of the National Federation of the Blind. How do I do this?

Please send me some information on this as soon as possible.

Thanks,
Angela Clouse

P.S. Keep up the GREAT work!

• • •

Grande Ronde, Oregon
January 1992

Ed Bryant, Editor
Voice of the Diabetic

Dear Fellow Diabetics,

I'm a 32-year-old male who has had Type I insulin-dependent diabetes for 25 years. Although I have had several complications due to diabetes, treatments have been very successful.

At 23 years of age, I started to develop diabetic retinopathy in both eyes. I started laser treatments in September 1982. The treatments lasted eleven months and did save most of my central vision, but I lost nearly all peripheral (side) vision. My vision is now 20/25 in the left eye and 20/20 in the right eye. If you need this treatment, I recommend you have it done. My ophthalmologist had told me that I would be legally blind in two months. Now, thank God, I can still drive.

Then, in 1986, I had a kidney transplant. I waited only five days for it. To this day, I have not had a rejection episode.

Also, I had angioplasty in 1988. In 1989, I had my gall bladder removed. In 1990, I had double bypass heart surgery. The only complication I developed from the bypass was walking pneumonia. I feel very lucky compared to others.

I am going to have a pancreas transplant. I believe in the staff's ability at my hospital, Oregon Health Sciences University. They have done eighteen pancreas transplants, and thirteen are still working. Those are very good numbers. I would also like to share with you that Blue Cross and Kaiser Permanentie cover this procedure.

I've also had severe neuropathy in my feet. Nothing would end the burning, tingling sensation until I was introduced to an over-the-counter vitamin, Inositol, that actually cured me. I took 1000 milligrams of pure Inositol three times a day for a month. I've been free of the burning and discomfort of neuropathy for over four years. It's very inexpensive and it works. I know.

I hope I've encouraged you somewhat and not discouraged or depressed you in any way. In life, we always have options.

Good luck,
Roger Shoff

Covering the gaps in Medicare

New rules to protect consumers

(Continued from page 15)

policies, and 75 cents on group contracts. (November 1991)

• **Penalties:** The law specifies penalties for violations. For example, sale of an unapproved policy will cost an insurer $25,000 and an agent $15,000; each violation of the open-enrollment rule, $5,500.

Note: Some federal safeguards might be less stringent than those already in effect under your state's law. Get guidance from the insurance department in your capital.

SHOP AND COMPARE

Before buying any Medigap policy, review Medicare's benefits and gaps. The chart accompanying this article will help.

Also, analyze your medical history and expenses, weigh potential out-of-pocket expenses for gap coverage against increased premium costs, and decide which services you would want a supplementary policy to pay for.

Then shop with several reputable insurers to compare policies. Be sure to compare plans carefully before deciding on which is best for you.

Tip: If you belong to a group, ask about group Medigap policies. You could save considerably in premiums.

For more information, including how to determine your Medigap needs, contact the following sources. Also look for updates in 1992, as the standardized policies become available.

• **Local Social Security offices.** For free, general Medicare information.

• **"Guide to Health Insurance for People with Medicare" (free) and "The Medicare Handbook" ($2.25).** Order from the Consumer Information Center, Dept. BHG, Pueblo, CO 81009.

• **"MEDIGAP: Medicare Supplement Insurance."** Stock No. D1404. For a free single copy, send your name and address on a postcard to: AARP Fulfillment, EEO157, Washington, DC 20049.

• **"Consumer Guide to Medicare Supplement Insurance."** Free from HIAA, P.O. Box 41455, Washington, DC 20018.

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Job Opportunities for the Blind

Job Opportunities for the Blind (JOB) is a joint project of the U.S. Department of Labor and the National Federation of the Blind. More than 1,000 job seekers have found employment through this unique program. JOB offers free services to U.S. residents who are blind and looking for work in the United States. Services include a nationwide reference and job referral service, a job hunter's magazine on cassette (the ***JOB Recorded Bulletin,*** published eight times per year), recorded job information literature, print materials for employer education, local and national career-planning seminars, consultation on low vision aids and appliances, and introductions to blind peers employed in the jobs of interest to the job seeker. For a sample JOB packet, call 1-800-638-7518.

Are you assisting a blind person to find a job? JOB offers additional free services and assistance to high schools with programs on transition to the world of work, to counselors of legally blind clients, and to other persons assisting blind applicants. JOB's volunteers are available in every state.

JOB offers employers free, nationwide job listings to locate competent workers who are legally blind, free consultation on cost-effective solutions for reasonable accommodation needs, and free educational seminars on hiring legally blind employees.

Vegetarianism and diabetes: are they a good combination?

by Claire Hammer, R.D.

We first must define the different kinds of vegetarians before answering this question. A **total vegetarian** avoid all foods of animal origin. A **lacto-vegetarian** excludes all foods of animal origin except milk and milk products. **Lacto-ovo-vegetarians** avoid all foods of animal origin except dairy products and eggs. A **semi or partial vegetarian** excludes only certain foods of animal origin such as just red meats. A non-pork eater would also be considered a semi or partial vegetarian.

As you can see, some vegetarians are stricter than others. Vegetarians who at least include dairy foods in their diets can eat a nutritionally adequate amount of protein. By choosing low fat dairy products, the calories and cholesterol can be controlled which is a very important consideration in diabetes. Vegetarian diabetics who include fish and poultry in their diet are adding variety as far as protein foods go without greatly increasing fat and cholesterol. Egg yolks are a concentrated source of cholesterol which any lacto-ovo-vegetarian should be aware of. The strict or total vegetarian diabetic presents more of a challenge in meal planning to ensure that not only is he/she obtaining a nutritionally sound diet but also one that will help manage his diabetes. Grain foods, nuts and legumes can provide excellent protein but sometimes the portion size needed to do this will result in excess calories. Also, since nuts, legumes and seeds are considered "incomplete" proteins, they need to be carefully combined with other foods to make a "complete" protein. This can be very difficult to do depending upon the availability of the foods needed.

In answer to our question, diabetes and vegetarianism are compatible depending on the degree of the vegetarian restrictions. Besides being difficult to plan, meal planning for the total vegetarian diabetic may conflict with the guidelines for optimal blood sugar management. The semi or partial vegetarian diabetic who excludes only red meats can easily obtain a diet controlled in fat and cholesterol as well as being appropriate for his/her diabetes.

(*Note:* This article originally appeared in *Dealing with Diabetes,* a newsletter for diabetics in prison.)

Ann Terry is a registered dietitian who works at the State Hospital in Fulton, Missouri and at the Veterans Administration Hospital of Columbia, Missouri. She graciously calculates the diabetic exchanges and food values for our recipes.

Send your great ideas to the editor. He is the official taste tester and needs recipes to test his taster.

Rosemary Chicken
Submitted by Karen Mayry
of Rapid City, South Dakota

4 chicken breasts — no skins
1 8-oz. cup low fat yogurt
Fresh rosemary leaves

Sprinkle chicken with garlic powder and pepper to taste. Place in baking dish. Cover with rosemary leaves and yogurt. Bake for one hour, covered, at 350°F. (One must judge amount of rosemary to one's own taste. It is more potent than dry rosemary and offers a delightful taste.)

Yield: 4 servings. Calories: 180. Diabetic Exchanges: 3 lean meat.

Eggplant Soup with Pasta
Submitted by Vickie Traylor
of Springlake, North Carolina

1 large onion, chopped
1 rib celery, chopped
4 cloves garlic, minced or crushed
2 tsp. olive oil
1 medium eggplant peeled and cubed (3-4 cups)
28 ozs. no-salt added tomatoes, cut up
2½ cups low sodium chicken broth or bouillon
¼ tsp. each: dried thyme, crushed rosemary
½ cup uncooked tiny pasta, orzo, stars

In a microproof three-quart casserole combine onion, celery, garlic, and olive oil. Microwave, uncovered, on high three minutes or until soft. Add eggplant and tomatoes. Microwave, covered, on high seven minutes or until eggplant is soft. Add remaining ingredients. Cover and microwave on high ten minutes or until pasta is cooked.

Yield: 8 servings. Calories: 85. Diabetic Exchanges: 1 vegetable, and 3/4 bread.

Low-Cal Slaw
Submitted by Gail Bryant
of Columbia, Missouri

1 cup white vinegar
2 tsp. salt (optional)
1½ tbsp. dry mustard
1½ tbsp. sugar substitute
1½ tbsp. chili powder
⅔ tsp. garlic powder
½ tsp. black pepper
Dash red pepper
8 cups shredded cabbage
1 cup shredded carrots

Mix dressing ingredients. Pour over vegetables. Let marinate overnight.

Yield: 12 servings. Calories: 25. Diabetic Exchanges: 1 vegetable.

Carmel Popcorn
(Note: This recipe was prepared by dietitians at Lookout Mountain Hospital, Spearfish, South Dakota.)

6 cups popped popcorn
2 tbsp. margarine
1 tbsp. honey

Spread popcorn evenly in large shallow baking pan. In small saucepan, melt margarine and blend in honey. Pour over popcorn, stirring to coat all pieces. Bake at 325 degrees for eight to ten minutes, stirring often. Cool slightly in pan before removing. Store in airtight container.

Yield: 3 (2 cup) servings. Calories: 125. Diabetic Exchanges: 1 bread, 1 fat.

What you always wanted to know but didn't know where to ask

(Resource list)

(Inclusion of materials in this publication is for information only and does not imply endorsement by the Diabetics Division of the NFB.)

Diabetic Foot Neuropathy

Some diabetics experience pain in their feet from neuropathy. Following are two products that may relieve discomfort, which for some is excruciating. Before using these medications, please consult your physician.

Capsaicin Cream: This cream is made from the hot pepper plant and reportedly wards off foot pain caused by neuropathy for some diabetics. Many consumers applied the cream four or more times daily and decreased the dosage over time. The price may be prohibitive, as a tube costs approximately $50 and usually lasts less than two weeks. Please check with your health care team prior to purchase of this product.

Inositol: This is an inexpensive over-the-counter vitamin that comes in dosages of 250 milligrams, 500 milligrams, and 600 milligrams. The maximum daily dosage is 3000 milligrams and should be taken in divided units. This pain-relieving tip was submitted by Roger Shoff, however, there is very little scientific evidence that vitamin therapy relieves neuropathy.

IMPORTANT: CHECK WITH A DIABETES SPECIALIST OR PODIATRIST BEFORE USING EITHER OF THE ABOVE SUBSTANCES.

Equipment

(Note: The prices indicated reflect a discount if customers write or say they saw it in the National Federation of the Blind Diabetics Division Resource Guide. The following three items may be ordered from Maxi-Aids, 42 Executive Blvd., Box 3209, Farmingdale, NY 11735; telephone toll-free: 1-800-522-6294.

New Count-A-Dose Insulin Measuring Device: Calibrated for use with B-D U-100 ½-cc syringes only. By turning a wheel, clicks are heard that measure one-unit increments. Holds one or two bottles of insulin for mixing; the needle penetrates the bottle stopper automatically. Instructions on cassette and in print are provided. Cost: $44.95 plus $3.00 shipping.

Count-A-Dose Insulin Measuring Device: Calibrated for use with B-D U-100 1-cc syringes. By turning a wheel, clicks are heard that measure two-unit increments. Holds one or two bottles of insulin for mixing; the needle penetrates the bottle stopper automatically. Instructions on cassette and in print are provided. Cost: $44.95 plus $3.00 shipping.

Weight-Talker III Scale: Has audio output capacity. Tells, in kilograms or pounds, weight gain or loss. Cost: $75.95 plus $3.00 shipping. Cassette instructions an additional $2.00.

B-D Magni-Guide: This device magnifies entire syringe scale by 2. It may also be used as a needle guide into vial stopper. Snaps onto Lilly, Nordisk and Squibb-Novo bottle caps. Usable with both 1 cc and ½ cc syringes. Cost: $4.30. Order through Becton Dickinson Consumer Products, Becton Dickinson and Company, Franklin Lakes, NJ 07417-1883; telephone toll-free: 1-800-526-4650.

Diascan-SVM Glucose Meter with Audio Output: Blood can be smeared on the test-strip pad and still produce an accurate clinical reading. The manufacturer offers a $125 rebate. Suggested retail price is $635. With rebate (and including cassette instructions) it is $510. A sample cassette is offered free upon request. Contact: Home Diagnostics, Inc., 51 James Way, Eatontown, NJ 07724; telephone toll-free: 1-800-342-7226; or call: 1-908-542-7788.

Accu-Drop Blood Sample Device: Blind diabetics and/or those with shaky hands may like this device. This instrument has a finger guide that may help diabetics, after puncturing a finger, in getting a drop of blood onto the center of the test strip pad.

The Accu-Drop was designed for bG chemstrips; however, Diascan strips may also be used. We don't know if other reagent strips will work with this device.

The suggested retail price is $12.00 to $15.00. Contact: Boehringer Mannheim Diagnostics, Inc., 9115 Hague Road, Indianapolis, IN 46250; telephone toll free: 1-800-585-8072.

From the Librarian

Our Diabetics Division librarian, Cheryl McCaslin, has information concerning all aspects of diabetes available on cassette and in print.

Cassettes are recorded with permission, from literature supplied by the Kentucky Diabetes Foundation. Titles include: High and Low Blood Sugar and Healthy Hygiene; Meal Planning; Urine Testing and Insulin Facts; Nutritional Care for Diabetes Mellitus; Personal Care Record with Food Diary; Diabetes Mellitus; and Nutrition Guide.

Cassettes, recorded at standard speed, cost $1.00 each. Please make tax-deductible checks payable to the National Federation of the Blind. Send orders to Cheryl McCaslin, 7717 Eastern Ave., Apt. B, Dallas, TX 75209; telephone: (214) 352-4974.

Cheryl reports that she has considerable print literature covering all aspects of diabetes. Articles are available in the following categories: Beating Diabetes; Diabetic Disorders; Diabetes — general information; Diabetes in Men; Diabetes in Women; Flying Solo — Managing Diabetes Alone; Hypoglycemic Reactions; Insulin; Neuropathy; Retinopathy; Self-management for Independence, and Transplants — Kidney and Pancreas. This information may be ordered from the address shown above.

Teaching Cards

Six new teaching cards instruct self-care concepts. With colorful illustrations and large print, the cards are written at a low reading level. Topics covered are: Planning Pregnancy With Diabetes, Diabetes and Neuropathy, Special Days (sick days, holidays, hectic days), Traveling with Diabetes, and Foot Care to Happy Healthy Feet. This series of teaching cards now has a total of 28 titles. Cost: Individual cards, $1.00; price of sets varies, depending on the number of cards. Order from: Kentucky Diabetes Foundation, 2220 Young Drive, Lexington, KY 40505; phone: (606) 268-9200.

Literature

Low Calorie Sweets by Charlet L. Snyder is a recipe book that lists sugar free desserts. It contains diabetic exchanges as well as complete nutrient analysis information for each item, as determined by a registered dietitian. Ms. Snyder, who is married to a diabetic, also includes a brief discussion of the advantages of various sugar substitutes. The sections provide recipes for beverages, breads and muffins, cakes, cookies and bars, pies, puddings and mousses, and miscellaneous goodies. Cost: $8.00, plus $2.00 shipping. Order from Charlet L. Snyder, P.O. Box 1421, Holland, MI 49422-1421.

A Touch of Diabetes: A Guide for People Who Have Type II, Non-Insulin Dependent Diabetes by Charles M. Peterson, M.D., Lois Jovanovic-Peterson, M.D. and Morton B. Stone provides information for the newly diagnosed Type II diabetic. Self-responsibility and self-management are stressed. Special concerns are discussed to help make the diabetic aware of, and prevent, complications. Cost: $7.95, plus $2.00 shipping. Order through Chronimed, Inc., P.O. Box 739, Wayzata, MN 55391; telephone toll-free: 1-800-876-6540.

It's Not All in Your Head by Bruce and Eileen Mackenzie. For the more than 10 million men and their partners who suffer from impotence. Help is available, you have a choice. Cost: $13.95 (includes handling). Order from: Impotence World Services, Box 5299, Maryville, TN 37802-5299.

Cassette and VCR Tapes

The following products may be ordered from: Impotents Anonymous (IA), Box 5299, Maryville, TN 37802-5299.

Lifelong Potency by Stephen M. Auerbach, M.D. is a 45-minute cassette which explains sexual dysfunction, impotence, and treatment options. Cost: $15.00, plus $3.00 shipping.

Impotence: Help and Hope by Bruce and Eileen Mackenzie is a 60-minute VCR tape for VHS only. This couple tells their own story, discussing an organized approach to overcoming affects of chronic impotence. They share ways of savings dollars and time-consuming approaches. Cost: $30.00.

Food for thought

National Convention

The annual convention of the National Federation of the Blind (NFB) will be held this year in Charlotte, North Carolina and attended by approximately 2,500 blind citizens. There will be fellowship and learning with informative program items, exhibits of the latest technology for the blind, and literature in Braille, print and on tape covering all aspects of blindness. Also, there will be exciting tours, which are always fun.

The activities will begin on Sunday, June 28, 1992 and end on Saturday, July 4, 1992. This year we will have booked four beautiful hotels with the convention taking place in the convention center. Two hotels are clustered around the convention center and the other two hotels are within walking distance. There will be shuttle service provided for those not caring to walk.

The unbeatable room rates are as follows: single $30, double/twins $35, triples $38, and quads $48. In addition, there is currently a 12% sales tax. The National Federation of the Blind will handle reservations to assure that everyone has a room. For reservations and information contact Convention '92, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230; phone: (410) 659-9314.

Reservations should be accompanied by a $40 deposit for each room requested. Please make checks payable to National Federation of the Blind. Mastercard, VISA, and Discover are also accepted.

Charlotte, North Carolina is a hub for U.S. airlines and there are many direct, nonstop flights nationally. This convention will be great. So, start

(Continued on page 18)

Food for thought

(Continued from page 17)

packing, and we'll see you there.

Plan Ahead and Be Prepared

At this year's annual convention of the National Federation of the Blind there will be many in attendance who are insulin dependent diabetics. Each of us should have the foresight to bring extra insulin and syringes so as to avoid taking time out to go in search of a pharmacy. If the state of North Carolina requires a doctor's prescription, the added expense of a physician's visit would be necessary.

We insulin dependent diabetics should always be prepared for an insulin reaction. At a national convention the hotels are jammed with people and the restaurants are usually packed.

At every convention there are a few diabetics who undergo hypoglycemic attacks which, of course, can be avoided. THINK AHEAD! Always carry something sweet such as candy or glucose tablets that can be used for insulin reactions. We should be sure to have, in our rooms, snacks that will help control our diabetic food needs.

We diabetics can travel anywhere and do almost anything we want. One thing we cannot do is go without food. Our bloodstreams should have a balance of insulin and glucose. If there is not enough glucose (food) then we have an "insulin reaction".

"Plan ahead and be prepared."

Dialysis

During this year's national convention in Charlotte, North Carolina, dialysis will be available.

Individuals requiring dialysis must have a transient-patient packet and a physician's statement filled out prior to treatment. Patients should have their dialysis units contact the desired location in Charlotte for instruction on what must be done. Please schedule dialysis treatments around the first of May as Charlotte is loaded with tourists during the fourth of July week.

There is a mandatory prepayment of 20 percent (approximately $25) which must be paid before each dialysis treatment. This is the amount not covered by Medicare.

Following are three dialysis locations close to the Convention Center:

1. Mecklenburg Dialysis, 2321 West Moorehead Street, Suite 102, Charlotte, NC 28208; phone: (704) 333-5535. Contact Anne Sherrill, Director of Nursing. If patient has secondary insurance, the unit will file. This unit is open Monday through Saturday.

2. Metrolina Kidney Center, 928 Baxter Street, Charlotte, NC 28204; phone: (704) 348-2950. Contact Willa Humphrey. This unit is open Monday through Saturday.

3. Dialysis Care of Charlotte, 910 Pecan Avenue, Charlotte, NC 28205; phone: (704) 372-7979. Contact Kecia Robertson, Social Worker. If patient is on the drug called Peogen, he/she must bring their own medicine or a prescription. (Patient must pay for this drug.) This unit is open Monday, Wednesday, and Friday.

If your dialysis unit cannot confirm a space for you, contact Ed Bryant for assistance at: 811 Cherry Street, Suite 309, Columbia, MO 65201; phone: (314) 875-8911.

Descriptive Video Service

Following is part of a press release the *Voice* editor received:

What is DVS Home Video?

DVS Home Video is a new service created to make movies on home

My first national convention

by Carol L. Dobak

Carol Dobak received a BA degree in political science from Trinity College, Hartford, Connecticut. She graduated from the University of Maryland's law school, and passed the bar examination in the summer of 1990. She has been a member of the NFB since February. Carol Dobak is presently searching for employment.

As a newcomer to the Federation, having joined the Baltimore Chapter in February of this year, I attended my first national convention in New Orleans. I looked forward to the trip with great anticipation, as I was told by other Federationists what an unforgettable experience one's first NFB convention could be. Yet, I was not sure what to expect. While I knew, in general, of the various events and activities that would occur — the President's report, speeches by public figures, the banquet, division meetings, etc. — still I was apprehensive. Would my first convention truly be the extraordinary event I had been promised? As it happened, my fears of disappointment were unfounded. From my journey to New Orleans, I gained a greater understanding of the Federation, myself and my role in this organization.

Upon arriving in New Orleans and throughout the initial days of the convention, I was impressed at first not only by the sheer number of people gathered there, nearly 3,000 in attendance, but also by the diversity of the Federation's membership. I encountered students studying such diverse subjects as math and engineering, French, education and theology. I met lawyers like myself, teachers, businessmen and other professionals, persons from urban centers and rural towns, young and old people both. While one may find it simple to note than any large, nationwide organization, such as ours, naturally would be comprised of persons of all types from many varied backgrounds, what may not be as easily discernible is the unity and strength amidst such diversity. However, the Federation has accomplished this goal by making individual members feel part of the greater whole, a fact which I witnessed constantly during the convention. Through all the division meetings and seminars catering to differing career orientations and interests, the convention truly did offer something for everyone.

The unity of the NFB was readily apparent to me through numerous votes on resolutions taken on the floor of the convention, some of which were nearly unanimous. I also found a unity of thought when speaking with individuals about Federation philosophy and their beliefs about blindness and the full abilities of independent blind persons. This is not to say that I did not hear members express differing opinions, and I was equally impressed by the latitude individuals were given in explaining their opposing viewpoints and the patience with which they were heard on the floor of the convention. Again, the strength of the Federation, stemming from this unity of purpose, was obvious to me upon listening to the various high-ranking public figures who addressed the convention, including the Secretary of the U.S. Department of Health and Human Services, the Chairman of the Republican National Committee, and numerous congresspersons and other government officials. An organization that can command the attention of such persons is most certainly a powerful force in the lives of the blind. Nothing could be more clear to me after attending my first convention.

However, the aspect of the Federation about which I learned the most and the one which made the greatest impression on me, is the deep-rooted supportive nature of the organization itself and its individual members. I learned of this on many occasions during my stay in New Orleans. The President's Report given by Mr. Mauer enumerated numerous instances in which the NFB had been of assistance to its individual members during the past year, including battling Social Security and other government agencies to right wrongs done them or to obtain services owed. During the meeting of the National Association of the Blind Lawyers I heard of other cases in which the NFB and its members had acted to assist other Federationists in their struggles with discrimination based on blindness. In addition, I observed countless occasions when Federationists gave their advice freely, shared job information, gave spontaneous cane travel lessons and discussed their personal experiences of blindness with others, all in an effort to help and support fellow members. I must admit that I was on the receiving end of much of this support.

Nonetheless, I do not mean to suggest that the Federation is in the business of coddling its members. On the contrary I learned that to be a Federationist is to be challenged, both personally and as a member of this organization. This is an aspect of the Federation of which I was not fully aware until my first convention. I believe that Dana Elkar, a blind actor, expressed this sentiment quite clearly and eloquently when, during his presentation before the convention, he described an incident in which he was encouraged by other Federationists to use his cane to find his way to his hotel room on his own for the first time. I too was challenged to receive my first cane travel lesson with sleep-shades, a somewhat disconcerting experience, but one for which I am grateful. Once again, I witnessed numerous other instances in which this scenario was played out, Federationists challenging fellow members to become more independent blind persons. However, I realized to a greater extent than before the convention that this is not the full scope of the challenge. I learned that for me being a Federationist means using what the NFB and its members have given me in terms of support to contribute, myself, to the organization and other members. This was certainly the single most significant impression made on me during my stay in New Orleans.

I understand that everyone's first convention experience is, generally, very rewarding and exhilarating, but I know also that on a much more personal level the experience of each is entirely his or her own. For me I realized a greater sense of independence and a desire to become more actively involved in an organization which, up to this point, has done so much for me. For others, I am sure that their first conventions have meant something altogether different to them. However, I hope that my impressions which I have related above have helped some readers to better understand the worthwhile experience which one's first convention can be and, perhaps, I have encouraged them to attend their first in Charlotte, North Carolina this year.

(*Note:* This article appeared Fall 1991 in ***The Braille Spectator,*** published by the NFB of Maryland.)

video accessible to blind and visually impaired people by providing narrated descriptions of the movie's key visual elements without interfering with the movie's dialogue or sound effects. The narration describes visual elements such as actions, locations, costumes and body language.

How many movies are available through DVS Home Video?

Currently, there are ten titles available for purchase at regular retail prices through the DVS Home Video catalogue. More titles will be added with each catalogue. The next catalogue is scheduled for early spring 1992. We would like your input about movies that you would like to have described. (*Editor's Note:* I purchased two DVS Video movies and found them enjoyable as they were narrated well. I acquired the movies Ghost for $19.95 and Honey, I Shrunk the Kids for $22.99. I paid about $2.50 shipping.)

How do I purchase a DVS Home Video movie?

DVS Home Video Movies may be purchased by calling 1-800-736-3099 ext. 31 and giving the customer service representative the following information:

- Your credit card number and expiration date
- The movie title(s) and catalogue number(s)
- The two-digit code from the address label on the back of the catalogue or on the order form of the catalogue.

DVS Home Video accepts VISA, MasterCard, American Express and Discover. Shipping and handling charges (plus sales tax for Minnesota residents) will be added.

Do I need special equipment to watch a DVS Home Video movie?

To watch a DVS Home Video movie and hear the descriptions, you will need only a regular VHS video cassette recorder (VCR) and a television. No special feature or device is needed. The movies are "openly" described so that everyone in the room watching the video may enjoy the movie with description.

How do I obtain a catalogue?

DVS Home Video catalogues may be obtained by calling 1-800-776-8066 and requesting that your name be placed on our mailing list. The first DVS Home Video catalogue is available in large print only but subsequent catalogues will be made available in large print and audio. Please specify which format you would like to receive.

Hear Ye, Hear Ye, A Raffle

The Diabetics Division of the National Federation of the Blind (NFB) reaches out and provides support and information to many people. This valuable networking costs money, such as the production cost for the *Voice of the Diabetic,* and we must generate funds to help cover these costs.

Our Diabetics Division has elected to hold a raffle which will be coordinated by our capable treasurer, Bill Parker. The grand prize will be $200 and the winner's name will be drawn at this year's annual convention of the National Federation of the Blind on Friday, July 3, 1992, in Charlotte, North Carolina. In addition to the grand prize, the person who sells the winning ticket will receive $100.

The cost of each raffle ticket is one dollar, or a book of six may be purchased for five dollars. Tickets may be purchased from state representatives of our Diabetics Division or by contacting raffle ticket chairman, Bill Parker, Lafayette Tower, 4601 Mayflower Road, Apt. 2D, Norfolk, VA 23502; phone (804) 623-1638. Anyone interested in selling tickets should also contact Bill.

Please make all tax deductible checks payable to the National Federation of the Blind. Money and sold raffle ticket stubs must be mailed to Bill Parker no later than June 15, 1992, or they can be personally delivered to him at this year's convention in Charlotte, North Carolina, June 28 through July 4. This raffle is open to everyone and raffle participants need not be present at the drawing to win.

Lessons from a Goose

(Note: This article was originally played on the January *National Federation of the Blind Presidential Release* cassette.)

Last fall when I saw some geese flying in a V formation, heading south for the winter, I wondered why they flew in that particular formation. I found out that scientists have learned that, as each bird flaps its wings, it creates lift for the birds immediately following it. The V formation is estimated to add seventy percent to the flock's flying range. There may be some lessons for us here. *Lesson Number One:* Those who share a common direction and sense of community can get where they are going more quickly and easily because they travel on the thrust of one another's efforts.

Whenever a goose falls out of formation, it suddenly feels drag and air resistance from trying to go it alone. It quickly gets back into formation to take advantage of the lifting power of the bird immediately in front. *Lesson Number Two:* If we have as much sense as a goose, we will stay in formation with those who are headed the same way as we are.

When the head goose gets tired, it rotates back in the wing and another flies point. *Lesson Number Three:* It pays to take turns on hard jobs for people as much as for geese.

The geese honk from behind to encourage those up front to keep up their speed. *Lesson Number Four:* We need to be careful of what we say when we honk from behind.

Finally, when a goose gets sick or is wounded and falls, two other geese drop out of formation and follow it down to provide help and protection. They stay with it until it is either able to fly or is dead. Then they set out to catch up with their flock, flying on their own or with another group. *Final and most important lesson:* If we have the sense of a goose, we will always stand by one another.

Display Tables

This year's annual convention of the NFB will take place in Charlotte, North Carolina, Sunday, June 28 through Saturday, July 4, 1992. At this momentous event our Diabetics Division has reserved space in the exhibit hall.

There will be hundreds of display tables with products and information that may be of interest to blind persons.

Our Diabetics Division will display literature and equipment that will be of interest to blind diabetics or to anyone interested in diabetes.

CAN YOU HELP? It takes many people to work the display tables, and if you can help for two hours, four hours, or more, please contact our display table chairman: Bill Parker, Lafayette Tower, 4601 Mayflower Rd., Apt. 2D, Norfolk, VA 23508; phone: (804) 623-1638.

A Guide to Guide Dog Schools by Ed Eames

Gardiner and Gingold describes the ten guide dog schools in the United States. It covers topics ranging from application procedures to contact after graduation. In addition, the costs and benefits of working with a guide dog, myths about guide dogs and the potential impact of a guide dog on your life are discussed. The 102-page book is available in print at a cost of $5, or NLS format cassette at a cost of $3.50. Checks should be made payable to Disabled on the Go (DOG) and sent to Ed and Toni Eames, 3376 North Wishon, Fresno, CA 93704.

Elections Coming Up

At this year's national convention in Charlotte, North Carolina, elections will be held to fill divisional board positions. These are one-year terms that will run from July 1, 1992 to June 30, 1993. Positions to be filled are: President, First Vice-President, Second Vice-President, Secretary, and Treasurer. If you are interested in a board position, or know someone who you think would do a good job, then contact our Diabetics Division President, Karen Mayry. Yes, hard work and dedication are prerequisites for each board position. Anything worthwhile is usually challenging and requires hard work. Leadership should be a positive force, and one should lead by good example.

Large Print, Cassettes, and Tape Players

Some subscribers have ordered the *Voice* in large print format. We do not produce our magazine in extra large print for the legally blind simply because the cost would be prohibitive. If the print were extra large, the cost of production would skyrocket by several thousand dollars.

Legally blind subscribers having trouble reading the print, can receive the *Voice* on audio cassette at no extra charge. These tapes are recorded at 15/16 inches per second (ips), which is slower than the standard speed of 1⅞ ips. If the *Voice* tape is played in a standard recorder, it will sound as if it is going too fast like a chipmunk.

Anyone who is legally blind may receive, at no charge, a special tape player that can be used for *Voice* tapes as well as other materials. To repeat: any blind person may receive a tape player at no cost.

Tape players may be ordered from Regional Libraries for the Blind and Physically Handicapped; or contact the Library of Congress for the Blind; phone toll free: 1-800-424-8567. These tape players are mailed as Free Matter for the Blind.

New Low Vision Research and Care Center

(Note: The following was received from Johns Hopkins Medical Institutions, Baltimore, MD.)

An erector-set-style box big enough to hold a man, a parachute harness and a five-by-seven foot high-resolution television screen are some of the tools Johns Hopkins investigators are using to study, diagnose and treat disabling low vision. Their work could aid an estimated three million Americans to live independently.

Low vision is a major focus of the Johns Hopkins Wilmer Eye Institute's new Vision Research and Rehabilitation Center. The center, named for the Multiple District 22 Lions Club, offers patient care, dispenses low vision aids and helps patients adjust to impaired eyesight.

Low vision is defined as sight impairment that cannot be corrected with medicine, surgery or eyeglasses. The impairment interferes with reading, independent travel, daily living and work.

Investigators in the Center's nine laboratories use equipment such as a $100,000 scanning laser ophthalmoscope, one of five in the world that combines computer graphics and low-power lasers to make video pictures of the eye's interior to learn how low vision patients see. Using a helium neon laser, similar to the ones used in grocery store checkouts, and one of infra red, the scope scans the retina to make a map that scientists use to determine how different parts of the retina see images.

"As the U.S. population increases, so will cases of low vision and the critical need for medical services and devices to help such patients," says Donald E. Banker, president of the International Association of Lions Clubs, long known for its support of eye disease research. "We are

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Food for thought

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pleased to support the efforts of the Wilmer Eye Institute to address these needs and pioneer new therapies for low vision patients."

Introducing ...

Texas Federationist Mrs. Dale Pierce introduces herself.

(Editor's Note: The following was received at the *Voice* office from Mrs. Dale Pierce. She has also submitted other materials which will be used in future editions. The poem which appears at the end was received with her correspondence.)

I have been a severe diabetic since the age of 35. I am the mother of five children and active in all their activities; scouts, sports, and church work. My husband is a busy doctor of chiropractic and I was his assistant and receptionist for 15 years.

After all our children were in school, I attended college and later became director of the Wichita Falls Neurological Foundation. Under a research program, we worked with brain-injured children and adults.

After a severe bout with diabetic coma and the aftermath of recuperation, I had to stop working. At about the same time, my sight deteriorated so much that I stopped driving. After four years of intensive laser treatments, all avenues to save my eyesight have gone. I have been to Criss Cole Rehabilitation Center in Austin, Texas. Learning good cane travel and basic Braille have held me in good stead. I use a talking blood glucometer and with other aids and appliances remain as independent as humanly possible.

With a magnificent husband, caring, loving children and grandchildren, a rich bounty of friends, and good people I meet daily, I do feel thankful for the abundant life I am able to lead.

I am a member of the Board of Directors of the Wichita Falls chapter of the National Federation of the Blind of Texas.

Think deeply, Speak gently,
Laugh often, Listen wisely,
Give generously, Love much,
Pray earnestly, And be kind.

Computer Banking

The following is a tip Don Andrews from Williamsburg, Virginia, wishes to share with *Voice* readers.

You don't have to have any type of impairment to benefit from the information I'm going to share with you. I'm sure you, like most people, find paying bills a chore you could do without. While with my method, you still have to pay your bills, you just don't make the payments yourself!

I found a service provided by Philadelphia Savings Fund Society (PSFS) of Philadelphia, Pennsylvania. PSFS offers CD's, checking, savings, and all normal banking services. When you set up your checking account with PSFS, you give them a list of all the merchants you make payments to on a monthly, quarterly, annual, or weekly basis. For payments such as your car payment, mortgage payment, life and/or health insurance, which remain constant each time, you just include the amount and frequency of the payment. For those bills that are not constant, such as your electric bill, phone bill, charge accounts, etc., you just list the merchant. For each merchant (payee) listed, you will need to give your account number and provide a complete mailing address and telephone contact. For a service fee of $10 per year, PSFS will deduct these payments from your checking account and mail them on the proper due date or as you direct them by phone.

Since I have my Social Security check and my dividend checks directly deposited, I never have to use a single stamp! As you can see, if you pay only four bills per month, it would cost you almost $14 per year at 29¢ for each stamp. As well as the savings in postage, there is the added convenience of not having to write all those checks, which can be very time-consuming if you are blind or have any handicap (including poor penmanship). The peace of mind that you get from knowing you won't miss a payment or ever have to pay a late charge is just icing on the cake!

You may call PSFS at their toll free number, 1-800-654-7737, for further details and an application. I've used this service for over a year and recommend it to all.

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Effective advertising doesn't scream at its audience. It persuades. It sells. The key to cost-effective advertising is making your voice heard where an audience is already listening. *Voice of the Diabetic* offers such an outlet. Make *your* voice heard. For advertising information contact:

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Membership/Subscription/Donation Form

The ***Voice of the Diabetic*** is a quarterly magazine published by the Diabetics Division of the National Federation of the Blind (NFB) for anyone interested in diabetes, especially diabetics who are blind or losing vision. It is an outreach publication emphasizing good diabetic control, diet, and independence.

Because production costs exceed subscription rates, all donations are accepted and very much appreciated. Most people prefer membership. To subscribe without becoming a member, the institutional rate must be paid.

You may receive the ***Voice*** as a member or at the institutional rate. **Please check one:**

☐ I would like to become a *member* of the NFB Diabetics Division and, as a member, receive a free subscription to the ***Voice of the Diabetic.*** Membership fee is $5.00 per year. (Members of our Division enjoy certain advantages, such as, if side effects occur, members can be put in touch with others who have had similar experiences.)

☐ I would like to subscribe to the ***Voice of the Diabetic*** at the institutional rate ($15.00/one year; $28.00/two years; $40.00/three years.) (Higher rates reflect actual $15.00 production cost per year.)

Send the ***Voice*** in (check one): ☐ print ☐ cassette tape for the blind (at no extra cost, recorded at 15/16 IPS) ☐ both

Optionally, check this box:

☐ I would like to make (or add) a tax-deductible contribution of $_____ to the Diabetics Division of the NFB.

Please print clearly

Name _____

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Send this form or a facsimile along with your check to our editor:
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Please make all checks payable to:
NATIONAL FEDERATION OF THE BLIND